California Workers' Compensation

Improving the Quality of Care for Injured Workers in California:

Focus Group Discussions

Research Report

November 2001

Division of Workers' Compensation
Department of Industrial Relations
San Francisco, California
and
Public Health Institute
Berkeley, California

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This report is available on the Internet
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State of California
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Executive summary

During the year 2000, the California Division of Workers' Compensation (DWC) held focus group discussions on health care quality for injured workers in California's workers' compensation system. The separately conducted sessions—with injured workers, employers, physicians, nurse case managers, claims adjusters, applicants' attorneys, DWC judges and information/assistance officers—were part of a larger project to assess needs and recommend improvements for injured worker care.

The specific aim of the focus groups was to understand diverse perspectives of participants in the workers' compensation system concerning quality of care for workers injured on the job.

The focus groups looked at quality of care in the general health care system, and for injured workers in particular. The participants all agreed on the fundamentals of health care quality, and on the nature of concerns regarding quality of care in the general health care system.

Access to medical care and to specialists, timeliness of care, adequate time spent with providers, good communication with doctors, and competency of providers were considered necessary to high quality health care. Participants in all groups also voiced concerns regarding intrusion of managed care organizations and insurers in the care delivery process.

All groups agreed that consumers have little access to information about what constitutes health care quality, and that most individuals choose their doctor and health plan based on personal recommendations, cost and convenience. They also agreed that the basic components of high quality health care are the same in workers' compensation as in other settings, and most groups identified functional outcomes and return-to-work plans as key to workers' compensation health care quality.

One striking finding was that the distrust pervading the workers' compensation system was widely viewed as both a quality of care problem and a barrier to quality improvement.

In every group, the intrusion of medical-legal concerns into the treatment arena was raised as a problem.

Other areas of concern specific to workers' compensation quality of medical care are:

- Physicians' lack of familiarity with occupational medicine, disability prevention, return-to-work issues, and the workers' compensation system.
- Access problems, including access to specialty care and to physicians willing to treat injured workers.
- Lack of information on the performance of workers' compensation medical providers.
- Lack of accountability of health care providers, or other parties such as insurers, for quality of care problems.

Focus group participants offered an impressive array of suggestions for improving the quality of care for workers injured on the job:

- Provide more information for injured workers, employers and providers about medical care in the workers' compensation system.
- Improve accountability by instituting performance measures for health care providers and managed care organizations, including standardized patient satisfaction surveys and consumer report cards.
- Require certification for physicians providing treatment within the workers' compensation system.
- Improve training for claims adjusters and streamline their workloads.
- Change financial incentives to encourage all parties to make high quality care and good outcomes for workers a priority.
- Encourage return to work through employer incentives or requirements, and through physician training.
- Provide ombudspersons for injured workers who can furnish information and help prevent litigation.

Background

Quality of health care recently emerged as a major concern due to increasing awareness of medical practice variations, medical errors, and underuse and overuse of medical services (CHCF overview on QOC problems[1], Millenson[2], Brook[3], Schuster[4]).

In the general health care system much effort is directed by purchasers, government and accrediting agencies, managed care organizations and researchers toward measuring and improving the quality of care (NAP Crossing the Quality Chasm[5], Bodenheimer [6], Donaldson[7]).

In its regulatory role of certifying and monitoring workers' compensation health care organizations (HCOs), the state Division of Workers' Compensation (DWC) began measuring injured worker care quality. DWC designed and administered a patient satisfaction survey to find out what the injured workers think about their own medical care in the workers' compensation system.

Serious concerns about the quality of care were raised in the injured worker focus group sessions during survey development, and following the patient survey results (Wiley[8], Rudolph[9], Rudolph[10]). Similar concerns emerged from the University of California's Labor Occupational Health Program focus groups assessing injured worker experience with California workers' compensation (Sum[11]).

With funding from the National Institute of Occupational Safety and Health, DWC and the Public Health Institute conducted the research project, *Physicians and Return to Work*, in which physicians treating workers' compensation low back pain were surveyed on their beliefs about low back pain treatment and return to work. Survey results suggest substantial variation in physician beliefs and practices (NIOSH technical report[12]).

Other researchers have documented substantial deviation from recommended treatment guidelines for workers' compensation low back injury (Mardon[13], Tacci[14]). Taken together, these findings convinced DWC of the urgent need to assess and improve health care quality for California's injured workers.

In 1999 DWC received funding from the RWJ Workers' Compensation Health Initiative for a project to develop a plan for a state technical resource center—California Work Injury Resource Center—that facilitates improved workers' compensation health care quality.

Project components included a literature review on quality improvement techniques, discussions with key participants regarding medical care for injured workers in California, assessing current workers' compensation utilization review practices (DWC Research Brief 2001-2[15]), and the focus groups described in this report. With funding from the Agency for HealthCare Quality and Research, DWC also sponsored a workshop, *Improving the Quality of Care for Injured Workers in California*, in May 2000 in Oakland. (See Appendix 3, Workshop Summary)

The goal of the focus groups was to elicit the views of a broad array of stakeholders in the state's workers' compensation system regarding health care quality—particularly their concerns about injured worker care—along with ideas for improving the medical care of injured workers.

A focus group moderator conducts structured group interviews and guides discussion of the issues of mutual interest. Focus groups are a valuable tool in qualitative research, as group interaction can produce insights otherwise less accessible (Morgan[16]; Krueger[17]). Focus group participants are identified by their particular stakeholder group. This allows for the free flow of ideas while protecting their confidentiality.

This report describes the focus group methodology and findings, which include ideas that emerged from the groups for improving the quality of care for injured workers in California's workers' compensation system.

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Methodology

Recruitment

Focus group participants were recruited by notices posted where they would be seen by members of the groups of interest, and by notices mailed to selected organizations. (See Appendix 1, Sample Recruitment Notices)

Injured workers: Notices for the injured worker group were posted at the Workers' Compensation Appeals Board (WCAB) offices and several occupational health clinics in Oakland and San Francisco. The notices asked interested workers to call the Public Health Institute for information.

Workers responding were screened to select those who met three criteria: period of injury, English-speaking, and availability on the date scheduled in Berkeley at the Public Health Institute. They were also given an incentive of $50 paid upon conclusion of the group session.

Employers: Invitations were sent to the members of Californians for Compensation Reform and the Disability Management Employer Coalition. Employer focus groups met at a rented office in downtown Sacramento and at a hotel close to the Los Angeles Airport.

Physicians: Notices were sent to industrial/occupational medicine clinics listed in the Oakland and San Francisco telephone books and Bay Area Kaiser On-the-Job clinics, with a letter to the clinic manager explaining the purpose of the focus groups and requesting that notices be posted in a location clearly visible to clinic physicians.

Physicians responding were asked to verify that they actively treat workers' compensation patients, and that they were available for the full duration of the discussion group in San Francisco at DWC headquarters. They were also given an incentive of $100 paid upon conclusion of the group session.

Nurse case managers: Notices were sent to members of the California Workers' Compensation Institute Medical Committee, with a letter that explained the purpose of the focus groups and asked for nurse case managers in their organization to be notified and allowed to participate in the group. Notices were also sent to certified HCOs with a letter requesting participation by HCO nurse case managers.

Those responding were asked to verify that they actively participate in workers' compensation case management, and that they were available for the full duration of the discussion group at DWC headquarters in San Francisco.

Claims adjusters: Notices were sent to members of the California Workers' Compensation Institute Claims Committee, with a letter that explained the purpose of the focus groups and asked for front line claims adjusters in their organization to be notified and allowed to participate in the group.

Those responding were asked to verify that they actively participate in workers' compensation claims adjustment, and that they were available for the full duration of the discussion group at DWC headquarters in San Francisco.

Applicants' attorneys: Leaders of the California Applicant Attorneys Association were invited to participate in a focus group session held at the organization's annual conference in Santa Barbara.

Judges and information/assistance officers: The Division of Workers' Compensation deputy director and regional managers were asked to notify judges and information/assistance officers in WCAB district offices near the locations where the focus groups would meet, and to authorize their participation. Judge focus groups met at the Oakland and Van Nuys WCAB offices.

Focus group process

Guides developed by Dr. Linda Rudolph, DWC medical director, and Kathy Dervin, MPH, DWC senior health education consultant, contained questions with slight variations tailored to the different focus groups. (See Appendix 2, Focus Group Guides)

Questions were based on literature pertaining to patient and other perspectives on health care quality, earlier discussions with key participants, prior injured worker focus group sessions conducted by DWC and the University of California Berkeley Survey Research Center while developing the patient satisfaction survey, and discussions at the May 2000 workshop, *Improving the Quality of Care for Injured Workers in California*.

The standardized set of questions ensured consistency across groups and minimized the impact of any potential bias of focus group facilitators.

The focus group sessions were led by Rudolph and Dervin, recorded on audiotape and transcribed by a transcription service. The facilitators and an observer also recorded notes.

Two major topics were explored: participant views on the quality of general health care, and health care quality for injured workers within California's workers' compensation system.

The introductory discussion about quality of medical care outside of workers' compensation served to encourage participants to speak about personal experiences—which provided a foundation for detailed discussion of quality of care—and determined similarities and differences between perspectives regarding personal health and care within the workers' compensation system.

Second, a set of questions was posed pertaining to the quality of care within the workers' compensation system. These questions allowed participants to share their perceptions and experiences of workers' compensation medical care, to identify problems and recommend improvements. The confidentiality and anonymity of the information obtained was assured for all participants.

A research associate, Joshua Linford-Steinfeld, identified themes common to all focus groups. A more detailed analysis of the methodology used in this focus group study is available on the Internet at http://www.dir.ca.gov/dwc.

Summaries compiled for each focus group session consisted of observations and examples related to each of the identified themes. The documents were used to produce a complex matrix listing similarities and differences among groups.

Matrix results were synthesized to address findings in these areas:

- Quality of medical care.
- Workers' compensation issues.
- Perceived barriers to health care quality and improvement of quality in workers' compensation medical care.
- Ideas for improving the quality of care for workers injured on the job.

Transcripts were reviewed for quotations representing the range of opinions expressed by focus group participants. The quotations were categorized based on relevancy to each section of this report narrative, and quotes best evoking the sense of the groups were selected.

Quality of care

Participants in each focus group were asked to define "quality" based on their experiences with personal health care for themselves and their families, outside the workers' compensation system. These discussions were surprisingly frank—many individuals shared details of their own medical stories, personal histories and experiences.

Although the participants represented a diverse set of socio-economic, cultural, educational and employment backgrounds, there was remarkable consensus about components of health care quality. Key aspects of quality as defined by all groups are access, expertise and the doctor-patient relationship.

In all groups multiple comments expressed concern about the impact of managed care on quality. Participants also addressed the complex interplay between cost concerns and quality issues, raising the concept of value for the health care dollar.

> **Injured worker**…I think quality of care should definitely be competent and scientifically sound. I think it should be humane. I think it should be interactive and cooperative and educational and consumer-oriented. I definitely think that when you're talking about the quality of medical care, the patient should be treated like a human being, not like a subject or an object. Or a paycheck.
>
> **Judge…**Quality…is that you want to be confident that the person who you go to see is a doctor who's competent to treat you and who can diagnose the injuries accurately, who will also provide you with the type of treatment that you need without trying to milk it or being restrained because of different regulations from the providers who are overseeing whatever they're doing.
>
> **Judge…**And the other thing is really the accessibility, to be able to get in, to see him, to have it done, to be able to have that contact, if you have complications or needs and you want to communicate that, to have a person who you feel that you can communicate those concerns to, who's competent and qualified to do something about it once they hear.
>
> **Judge**…For me, quality of care means getting the best medical attention and care that I, as a patient, should be entitled to, have a true doctor-patient relationship, and that the doctor puts my needs ahead of all others, in terms of his own situation. And…that would include having available to me appropriate resources, medical resources and diagnostic testing services and second opinions, and getting care quickly.
>
> **Nurse case manager**…the unfortunate result of managed care is…cost [has] become the central focus rather than quality and I don't really see that as something that's easily turn[ed] around. The focus…has been pushed more and more towards…cost issues: time in the hospitals, time with the doctor.
>
> **Employer**…I was very impressed with the care that he [family member] received, and he also had an HMO. So at that point I kind of changed…I'm like everybody else, I've heard all the stories. And you say HMO and they all go, "Sssss," but I think after that I may have to rethink. I may not always agree with some of their practices, but I think the doctors themselves are still quality.

Access: There was unanimous agreement that access to providers—including specialists—is crucial to health care quality. While there were some concerns about gatekeepers and managed care organizations impeding referrals to specialists, several participants noted their positive experiences in getting the care they or family members needed without difficulty.

The attorney group raised significant concerns regarding lack of access to basic health care for the many workers in California who have no health insurance.

> **Attorney**…I'm getting good care because I'm fortunate enough to be able to afford a PPO-type plan, which permits me to select a specialist without going through a gatekeeper.
>
> **Attorney**…a significant portion of my clients have no medical care.

Attorney…They [clients] rarely see a doctor. Everything from home remedies to whatever, but there's a significant portion, I think, of all of our clients that don't have PPOs or HMOs. The only thing they can rely on is the county facility, or emergency rooms where they sit for nine hours if they're not bleeding.

Judge…there is authorization problems… Service may not be available right there in the office, it has to be authorized someplace else and inevitably leads for [sic] a delay.

Judge…you get the real runaround, and God forbid if you've got some life-threatening condition because you'll be dead before you're referred to the specialist.

Timeliness of care was identified as another important aspect of access. Issues of timeliness include availability of after-hours care, time to appointments—both first and specialist appointments—time in the waiting room and exam room at appointments.

Concerns about adequate access to diagnostic services and failure of primary care physicians to make timely referrals to specialists were raised. Nurses also emphasized access to preventive clinical services, wellness care and public health programs. Availability of telephone and e-mail consultations with providers is appreciated, and gives patients the security of knowing they can obtain information quickly.

Nurse case manager…quality of care is extremely important and I wonder what people do all the time on the quality of care. I mean I was knowledgeable, what about people who aren't? And that concerns me, whereas primary doctors…sometimes hang on too long.

Employer…I think because of the health care system, and capping, and issues within the health care system, this hanging on is a huge problem. [In an] HMO, you're not going to get the diagnostic tests that you may need to determine what's going on, until you are the squeaky wheel over and over and over and over again and then they'll proceed.

Judge…Accessibility of the doctor is the biggest sticking point with me, so that I don't have to wait three days for a return phone call from even a nurse.

Participants prefer that health care be convenient, local, with easy road access and ample parking. Those experienced with centralized services liked the convenience of having pharmacy, x-ray and services such as physical therapy in close proximity to physician offices.

However, several people commented that convenience and waiting times were of secondary importance, noting that they would willingly travel long distances and wait for hours to see a doctor they believed to be "the best."

Employer…A lot of it has to do with the time. Everything is centralized, too, within that organization [an HMO]. Everything's there, the pharmacy, the hospital, the lab work, I don't have to drive here and there.

Judge…we really like it, because it's right down the street.

Judge…I look at the doctor and he's a nice guy, but I really don't know, exactly. He doesn't have the time to really talk to me much, and so I…think, "Well, I guess I kind of know what's going on [laughter]." But to me it's a balance of quality against convenience. And to me I'm sort of lazy…so I just go for convenience.

Expertise: There was also across-the-board agreement that competence and technical expertise on the part of providers are a critical element in quality of care. Expertise was defined in terms of skill, level and pertinence of training, experience and being up-to-date with the state of the art.

Some people hinted at the potential for overuse of medical services, raising concerns about prescribing treatments of unproven effectiveness or continuation of treatments that aren't working for a particular patient.

Physician…I think that quality would be the right care at the right time for the right problem.

Employer…Of course I wanted to make sure they're Board-certified and where they went to medical school and all this.

Judge…you want to know how many times the particular physician has performed this type of surgery.

Doctor-patient relationship: Various aspects of the patient-physician relationship were raised in every group as a third key component of medical care quality. Many people complained about the lack of time spent in face-to-

face contact with the physician, and its impact on communicating concerns to the physician and receiving adequate explanations about their illness or diagnostic and treatment plans.

> **Claims adjuster**…communication—that has been wiped out because, for the most part, there's a lot of pressure to see more and more people, so you don't get the communication and sometimes you're treated like a commodity instead of this is my body and I want to keep it for as long as I can.
>
> **Employer**…when health care is based on somebody caring, truly caring, and placing that as the priority and nothing else as the priority, then and only then will you see quality of care.
>
> **Injured worker**…I think patients need to be included in the decision-making process.
>
> **Nurse case manager**…Well, there may be technical quality but without the service component, the perception is that there's no quality. People have emotional needs around their health.
>
> **Injured worker**…one of the last doctors I saw at [an HMO] said I had seven minutes to tell him what was wrong. And I'm not even finished, he says, "I'll give you a prescription for bursitis," he thought I had bursitis. He hadn't looked at the CAT scan or the x-rays. So…right now there's no quality—there's no standard for care.
>
> **Claims adjuster**…They gave me about five minutes. I was really annoyed. I said he's treating me like a workers' comp patient.
>
> **Judge**…my primary doctor is referring me out to all these specialists because he doesn't have time to deal with my situation in his office, so he doesn't have time to deal with complex problems, so he just refers me out…which is an inconvenience to me.
>
> **Judge**…My primary care physician, at the last physical, told me "I'm allotted something like 8.2 minutes for each physical," and she's got a certain number that she has to do per hour, so if you ask too many questions—she told me, she says, "You're asking too many questions, you're cutting into the 8.2 minutes."

Individual preferences emerged within each group. While all participants valued patient-physician communication and recognized the importance of the doctor-patient relationship, individuals in most groups also expressed willingness to trade off physician communication skills and convenience in exchange for confidence in a particular physician's technical expertise.

> **Injured worker**…But I made a choice to stick with him because he happens to be the best physician for my type of injury.
>
> **Employer**…And I selected my husband's cardiologist because he did his fellowship at Harvard and, more important, he could communicate and would communicate, and by the way, we have to wait sometimes up to two hours to see him. Doesn't bother us at all [laughter]. Even my husband, who never waits for anything, has finally realized that this man knows his stuff, and he sits there patiently. So time isn't a factor.

Respect and trust: There was consensus on the importance of patient trust in the physician. Comments suggest that trust evolves from patients feeling cared about and respected by the physician, as well as from patient perceptions of physician expertise and knowledge. Complaints about disrespectful treatment—by both office staff and physicians—were also common.

> **Claims adjuster**…respect. I think all of us want to be treated as adults.
>
> **Claims adjuster**…That's what we would aspire to, that they treat people respectfully.
>
> **Injured worker**…this guy [a doctor] was so rude, I almost honestly felt as if this guy was trying to push my buttons.
>
> **Injured worker**…I want to be heard. I don't want to go to a medical practitioner and explain what my symptoms are and have them just be dismissed or be told that it was probably nothing. I want research done and I want someone to find out exactly what the problem is before the issue gets dismissed.

Continuity and coordination of care: The value of a long-term relationship with a provider was also noted. Concerns were raised in several groups about the continuity or disruption of care associated with changes in health plan or employer.

> **Nurse case manager**…The fragmentation just has been very burdensome for everybody…I feel like I've saved my family members many times over because I know what I'm doing. I feel sorry for people who don't have those skills. No wonder they're feeling really lost. It takes tremendous skill to coordinate everything now.

Nurse case manager…the doctor's a member of this plan one month. The next month he's not and next month you can't go down to Daly City.

Choosing health care: Participants were asked how they select a health plan or physician. Most indicated that they have very little information on which to base selection, and therefore must rely on referrals from family and friends.

Physicians and nurses felt they had inside knowledge about who the good and bad doctors are. Claims adjusters, employers and applicants' attorneys also stated that because of their work in workers' compensation, they were at an advantage over the average individual in picking high quality providers.

Several nurses said they had chosen a doctor or hospital based on specific medical problems faced by themselves or family members. Others based their selection of a plan or physician on availability of a particular hospital.

A few individuals reported substantial efforts to identify good doctors, through interviews and checking licensure and specialty boards. One used the Medical Board of California Internet site to investigate malpractice and complaints when selecting a doctor.

Although one judge mentioned using a rating survey in the popular press, none mentioned information on quality provided in report cards when choosing a health plan.

Injured worker…There's no way [to choose], it's a crap shoot.

Injured worker…Talk to people, this is not a third-world country. Make phone calls. Talk to family.

Judge…I really do think word of mouth, if you trust the people that you're surrounded by, is very key, and I haven't been let down yet.

Nurse case manager…How I make decisions around that is usually word-of-mouth, other people's recommendations.

Judge…my wife and I then sort of closed our eyes and picked three that were near the hospital where my wife was going to deliver.

Nurse case manager…No, I schlep to San Francisco for my primary care because I have to put up with the inconvenience because I don't want to go to [name of hospital].

Nurse case manager…I feel more comfortable in a bigger, state-of-the-art hospital.

Judge…So I chose an osteopath who turned out to be totally incompetent, and…it wasn't until I had the heart surgery that I found personnel who could help me choose another doctor.

Attorney…most of us have more money than the average worker, we have more knowledge of medicine, we have doctors who are friends, or at least say they're friends. And we have more access to the health care than the majority of people.

Judge…One of the differences for all of us is that we're all smart, educated, know not to be buffaloed, know ways around, know who to ask.

Employer…So quality of care is extremely important and I wonder what people do all the time on the quality of care. I mean I was knowledgeable, what about people who aren't?

Cost remains a major factor in the selection of health plans, although some were willing to pay for desirable plan characteristics.

Claims adjuster…really you are tied economically by what you do and your family circumstances. I think that really and truly is what most people do when they're looking at their health plans. How much is it going to impact on your pocketbook? And then you muddle along through whatever health plan you select.

Claims adjuster…I think I just look for whatever is the cheapest, just kind of playing Russian Roulette.

Employer…quite frankly, it was the cheapest plan.

Judge…The most important thing is being able to choose my doctor, especially for a more complex medical procedure. I've been even willing to pay extra to be in [plan name], to be able to choose my own doctor.

In sum, participants in all focus groups expressed remarkably uniform views about their general perceptions of health care quality: it should be accessible, competent, state of the art, caring, patient-oriented, patient-selected, and reasonably priced.

Workers' compensation quality of care issues

Groups were asked if any specific quality of care issues set workers' compensation care apart from general health care. All groups perceived significant differences between the care of injured workers and that of other patients.

> **Nurse case manager**…there are a lot of aspects to managing comp that are very unique and managing injured workers are different than group health. We have all those disability costs to consider. We have different cost-containment issues and other broader psycho-social aspects of the case from the physician's point of view that need management and that's an extra burden in an already burdened system so it's very important to send them to someone who's passionate, who cares, has the skills, and that's not a crap shoot. It takes a lot of energy.

While themes across groups were again similar, markedly different viewpoints emerged in discussions about trust, continuity of care, access and utilization review, return to work, and legal aspects of workers' compensation such as control of treating physician selection or the treating physician presumption (defined in California Labor Code, Chapter 7, Article 2, Section 4062.9).

Trust: The most striking and pervasive theme to emerge in every group was that of distrust—between and among virtually all of those who participate in the system of health care for workers injured on the job.

Claims adjusters and employers voiced suspicion of workers' compensation claimants. There was also a perception that workers feel entitled to time off work and compensation benefits, and that dissatisfied or problem employees will use an injury as an excuse for taking time off.

> **Employer**…the attitude is, "I got injured on the job, they owe me, I deserve these benefits, I'm entitled to these benefits, whereas if I get injured at home, I get back to work—it's on my own time, it's on my sick leave, I got to get back to work. And I get better anyway."
>
> **Physician**…But there's the whole system of entitlement that goes along with the workers' comp treatment and some of the perverse incentives that go with that.
>
> **Employer**…I think the worst-case scenario is where I clearly have suspected that the attorney has an incentive to see the injuries worsen and broaden in their scope—suspected because [laughter] it will increase the financial gain for the attorney…And that's reprehensible, and I suspected that in more than a few occasions.

Workers are sensitive to and resentful of these suspicions. They report that they feel criminalized and that their own physicians don't trust them.

> **Injured worker**…A lot of times, doctors don't believe the amount of pain you're in or the subjective complaints you're reporting, and you're treated like a sociopathic lying criminal when you see some doctors. The myth of workers' compensation fraud, of rampant workers' comp fraud, has to be publicly dispelled in a widespread manner.
>
> **Injured worker**…the claims adjuster was very adversarial from the start, and instead of allowing me to go see my own surgeon, who would have had all my records in history, she insisted that I go to this other neurologist …They're not going to care for you, they're only going to determine legally whether or not you have an injury.
>
> **Injured worker**…Everybody thinks you're lying about your injuries. Many of the treaters—even the good treaters—don't believe you, and I think it's because society believes injured workers commit rampant fraud. I don't believe it's true. The data doesn't prove it.

At the same time, several injured workers felt victimized and angry about unsafe workplaces, or unsafe actions on the part of an employer. They see their employer as responsible for their injuries, which could have been prevented.

> **Injured worker**…he's telling me "Hurry up, come on, let's go, let's go"…the boss, he owns the company…and he didn't even see if I was clear away from the trailer. Just set it down on my foot. He was careless, he was in a hurry. He's always in a hurry. That's all I got to say.

Workers also expressed fear that their injury and resultant work limitations could be used as an excuse to demote or fire them.

Judge…It used to be when you went to work for somebody, you were there for life, and the employer treated you as such, you were a valuable employee. Nowadays, it seems like you get injured on the job and, "We can replace you with somebody else. You're just a cog in the wheel that we can replace."

Workers and others distrust the company doctors they are sent to by the employer or insurer, uncertain whether these physicians can practice independently and be loyal to the patient, or are unduly influenced by the employer or insurance company on whom they rely for referrals.

Injured worker…the work comp system, they're just stacked. Those doctors are paid to write against you, and they are very lucrative …those people have gotten really rich off of, essentially, killing us.

Nurse case manager…Even the injured workers have their biases, too, like when they'll tell me they don't want to go to a company doctor…like that's the lowest thing they could offer me. I want to go to a private doctor. You might be working with a very good occupational med. M.D. …So you try to explain that and I think it's important to explain that if they're with a good doctor, stay there!

Injured worker…think of all the thousands and millions of people that do not know that and they're forced to go to that one company doctor and if they don't know their rights, then they're going to be up the creek, because the whole object for the insurance company is to get these people back to work as soon as possible. And I think that's the biggest problem with the workers' comp managed care.

Injured worker…you'll go see them, they'll write up a report, put it in their words, making it look like you're doing fine and everything's all good, like almost to the point of discharging you. If you don't keep track of that and write letters and follow up and dispute and correct their inconsistencies, as far as their reports are concerned, you're screwed either way it goes.

Injured worker…I was not treated with dignity. They wouldn't even talk to me in a closed setting, they would talk to me in the hallway. And I was outraged…how is that fair to a worker who goes in expecting to be treated in good faith, to be treated by somebody who doesn't have their best interest in mind?

Judge…those nurse people…can be very good, if you know who it is and the person's heart's in the right place and they are—But they're paid by the insurance company, which always is the problem.

Physicians are acutely aware of this distrust and frustrated that, even with tremendous effort, it is often difficult to establish a trusting relationship with patients who view them as the company doctor.

Physician…But you can give all that and the employee doesn't believe he's getting it, just simply because the company sent him to you. …if I wrote a biography—an autobiography of my clinical practice, the title for it would be "Practicing Medicine from Out of a Hole," because throughout my career, I've really never had patients that really wanted to see me. And you've got to establish their trust in you, and the only way that I've ever been able to do that is try and project care like a spotlight, that I really care about their problem.

Physicians also described tension between keeping employer clients and being advocates for their injured worker patients.

Physician…The patient is the injured worker, and then you've got the clients: the employer—and sometimes the employer is the comp carrier and administrator as well—but you've got the employer, you've got the insurance agent, insurance company, third-party administrator, whatever.

Physician…So you had to meet all of the traditional responsibilities to the patients, but you also had to meet those responsibilities to the client. But you had to make sure that the patient didn't feel that your responsibilities to those clients was outweighing your traditional responsibilities as a physician. And that's a real tough balance.

There was general consensus, most poignantly stated by workers, that injured workers often feel powerless when faced with an inordinately complex system. These feelings of impotence are exacerbated by distrust, by the fragmentation and discontinuity of health care, and by the common perception that the injured worker has no one on his/her side.

Injured workers talking in conversation…
I think that the system is designed to do that, to confuse us and to delay.
Exactly. And intimidate the workers to go back. Intimidate, terrorize.
Break them down.

Injured worker…There's a lot of people that are living off of us, profiting and doing well, the doctors and the lawyers and the insurance companies, at our expense.

Injured worker…it's real clear that there's no objectivity from the insurance and employer's standpoint. They don't look at a patient and say, "Okay, this is what this person has." It's, "Okay, we need to save money," or "we're going to save money, so we'll declare P&S or we'll say that she doesn't have this or that." If you go to someone objective, they're supposed to be but they're not. And a lot of workers lose benefits and many other things like their home and whatnot because of that aspect.

The importance of restoring trust in the doctor-patient relationship was raised in several groups.

Physician…it's probably a much more important component in workers' comp than it is in many other arenas of medicine because the patients have much more choice. So an important component of quality is that the patient believes that the provider who's seeing them really cares about them and is motivated to protect them physically and not take advantage of the doctor-patient relationship to satisfy an employer's agenda or an insurance company's agenda.

Judge…You have the doctor-patient relationship skewered, because the doctor is either beholden to the insurance company for sending that patient to them, or beholden to the applicants' attorney for sending that patient to them. It becomes more extreme with the treating doctor presumption, that's a bad law. But what you want to do is to raise the quality of the care, is somehow get that doctor-patient relationship back to what it is for the rest of us, that I trust my doctor is going to do the best thing for me.

Attorney…They have to have a doctor that they have faith in. If they don't, it's not going to work! And the industrial clinics' reputation in the plants is just lower than nothing.

Judge…And they [workers] truly want somebody who's going to give them an honest opinion, and if in fact they need to be rehabilitated, then that's a reality they have to live with, but I don't think they'd want to see a doctor who's going to puff up a report just to get them a little bit of money now and then perhaps ruin their lives by making them unemployable. So to that extent, they want a doctor who's going to give an honest opinion.

Several groups mentioned the value of having someone to help coordinate care, to keep workers informed, and to advocate for the worker.

Claims adjuster…injured workers question if the insurance company is telling them everything. They don't understand the paperwork, and they question their employers, because now the employers are treating them mean because they got injured on the job, and so they feel like who do I run to, who do I run to, and then they go and they get an attorney.

Nurse case manager…our role as nurses is always to be a patient advocate. Working for insurance companies…you get infected with their…they always have this healthy skepticism every time they get a new claim.

Employer…I think people often litigate because they don't know, they don't understand and they feel they need somebody to protect them.

Continuity and fragmentation: Concerns about continuity of care are heightened in the context of workers' compensation. The workers' compensation physician has frequently never seen the patient before, and both patient and provider know the relationship will be terminated at the end of treatment for the specific injury—or before.

Physician…In primary care, it's theoretically until death. You have a lifelong relationship with a primary care provider, in an ideal world, and come back if you have problems…open door. So we have a closed door, in [workers' compensation]…we want an end to a case as soon as it resolved, discharged as resolved …end of discussion.

Attorney…they frequently see a different physician every time they go there. So no one really knows…the patient really doesn't know that the physician they're seeing is aware of what their problem truly is, they have to repeat themselves frequently and they feel that they're not getting good attention for their medical problem.

Workers expect to be treated as a whole person, and some resented the focus on a specific work injury with seeming disregard for what the worker viewed as related problems. On the other hand, claims adjusters and employers were concerned that physicians *were* treating the whole person, making employers pay for treatment beyond that which is their legal responsibility.

Injured worker…I had…an orthopedic and a head injury and the workers' comp system only allows you to have one treating physician. It's like having one hand tied behind your back. Even though they say the treating physician can send you to another specialist, workers' comp has consistently refused to allow me to see the specialist for the other injury.

Nurse case manager…they start focusing on the whole patient, not the injury, which makes it very difficult to have to keep reminding them we're only covering this injury. We're not covering this whole body and that's a hard one sometimes with these other doctors.

Nurse case manager…With chiropractors, too, they're whole modality is to treat the whole person, which is a good, sound way to go, but dealing with the work comp system—when you've got a wrist, why are you massaging the knee?

Judge…I doubt that any injured worker who has a problem with a bad back, failed-back syndrome, plus a psychiatric condition, I doubt that they're ever treated as a whole person. I think they're chopped up into parts…it must just be a horrendous situation.

Many participants expressed concern about the large number of physicians seen by some injured workers. The workers themselves were particularly frustrated by the varied opinions of different physicians, and sensed that these opinions reflected "which side" a particular doctor is on.

Injured worker…He [the doctor] said he only sees people on Fridays and he wasn't going to be there for the next two Fridays so I'd have to see somebody else!

Employer…And these persons have gone to at least 15 different doctors, specialists as well as general practitioners, chiropractor, acupuncture, pain management, name it…I'm familiar with all of them. And it was an injury that should have been taken care by an orthopedic doctor…and it's like a game—game with human beings' lives, that's what I consider it.

Injured worker…I was seen by five doctors over a period of three months.

Injured worker…To be on the fifth treating physician is ridiculous.

Injured worker…In my case, I've seen, I believe, 9 to 11 doctors…I was seen by four doctors that the county sent me to. All of them disagreed with the input from all the other doctors that I had seen.

Several other legal aspects of the workers' compensation system—the treating physician presumption and the concept of permanent and stationary (P&S)—compound continuity problems.

Communication: Viewed by all groups as an issue of paramount importance in workers' compensation, the urgent need for improved communications among all parties was a recurrent theme. As in general health care, doctor-patient communication is an important component of care quality. The need for providers able to communicate effectively with non-English speaking clients was specifically noted.

Injured worker…I don't know even how to write or read in English. I'm sorry, lady. But I think I have the same rights also.

Injured worker…The doctor I have now, he's beautiful. I walked in there, the first thing he said was, "You tell me how your foot feels, I don't know." And that—I felt great right there. I like that.

Claims adjuster…The ones that you know are talking to their patients…they're calling you and saying well, I just saw my doctor…they know what's going on with their care and they're going okay.

Claims adjuster…And the classic—your doctor says you're P&S. Well, what does that mean? He didn't say anything to me, he just left the room and I was just there. Well, like you're done! It's over.

Employer…Of course, you've got the great specialists that are terrible communicators, too, so that's a tough issue.

Employer…The employee—we do check with them, "How did it go?" "Well, I don't know. The doctor didn't talk to me. He just told me to take these pills and that's it."

Attorney…I'm constantly encountering the fact that my Hispanic or Portuguese—whether they be bilingual or monolingual, whether they speak English or not—have a constant problem of being able to relate to these Western physicians: "Where does it hurt?" "Well, it hurts all through my leg." They don't know how to describe, they don't go to doctors.

Communication among other parties is also very important—employer-worker, employer-physician, claims administrator-physician communications were discussed.

Claims adjuster…they're [workers] upset because the employer hasn't called them just to ask how they're doing.

Claims adjuster…When they do hear from their employers it's "when are you getting back to work?" And it's more harassment than really caring for the injured worker, for the most part.

Employer…Every Monday, there's a phone call to that injured worker: "How are you doing?" A lot of it is to get information…[it] serves two purposes: to get information, to keep the contact with the employer…The second thing I think is very important is that quality time spent.

Nurse case manager…To me I need a communicator. I need somebody who's going to talk to me because it's very difficult to manage something if he won't talk to you. Writing is not an efficient way to conduct commerce. It's much more efficient if you can have a social relationship and it's somebody the patients like because the patients have to feel good about the quality, too. So they just can't be technically good, they have to have the interpersonal skills to sustain all the relationships in this area.

Physician…so the claims examiners don't have the knowledgeability and the lines of communication with the employers that they used to have.

Physician…One of the other casualties of my spending progressively—paying more in front-office time, with spending more time myself communicating with carriers, getting authorization, one of the casualties of that was that I had less time to talk to the employers. And I think that's a…real loss to both me and the employer.

Several participants pointed out that the multiplicity of players involved with a claim—sometimes even within a single organization such as a large insurer—can often create serious communication problems that affect the injured worker, the physician and the employer.

Physician…So you may have an adjuster, then you have a nurse case manager, and then you have the person who actually authorizes procedures, and they may be in different parts of the country. I mean, there can literally easily be three names on a chart of contact people …this fragmentation has developed just within the past few years…It's very disruptive.

Access: Health care access for injured workers surfaced as a major concern in almost all groups, who discussed the paucity of physicians willing to treat workers' compensation patients in some regions of the state, particularly in some specialties.

Attorney…I think there has to be more physicians who are willing to treat workers' comp patients.

Judge…finding decent doctors to treat your patients was one of the biggest problems I had doing applicants' work, because the vast majority of the medical community doesn't want to treat workers' compensation cases. I think if you go into the medical community and you ask the majority of doctors, would they treat workers' compensation or they want workers' compensation basis, I think you're going to find the vast majority of the medical profession says no.

Nurse case manager…You get the doctor who can give you what you need but because of all of the headaches that go along with having a workers' comp injury, they say I'm sorry, I won't deal with this.

Physician…I, who practice in more of a rural, or less urban, setting, we also just have a lack of people.

Attorney…I tell people there are two or three or four people who might be able to help you.... there's no neurologist I can refer them to.

Judge…there's very few doctors who will treat workers' compensation cases, and they sort of have a captive clientele, at least in this community.

Judge…if you really want to go to the very best surgeon for your back surgery, you ain't going to, because he's not going to do workers' comp, on account of he doesn't want to write all those reports and deal with the bureaucracy.

Judge…There's a limited few that will do surgery on you, but personally, I wouldn't go to them.

Judge…I think the biggest problem is that some of the top specialists—cardiovascular specialists and so on—are often the ones that just don't want to even touch workers' comp.

Attorney…in certain areas, because you don't have any choice…a lot of the physicians, including those who practice specialties like neurology, neurosurgeon, orthopedist, with a lot of work injuries, either don't have a clue as to workers' comp, or if they do, they've had enough of it, with all the bureaucracy and all the reports and whatever, they just don't want to do it.

Nurse case manager…doctors…won't take a patient because they're workers' comp.

Judge…particularly in smaller clinics that don't have any doctors. If you ask for a QME, we don't have three QME doctors in several specialties in the whole town, and we're a town of a quarter million.

Focus group participants recognize that access is worse for the many injured workers who lack health insurance.

Attorney…Initially, the real question is no care vs. the quality of care. So many of our clients come to us and they're not getting any care, and were it not for us, they would continue to get no care.

Attorney…I got to tell you that a significant portion of my clients have no medical care. They rarely see a doctor. Everything from home remedies to whatever…The only thing they can rely on is the county facility or emergency rooms…So if you're talking about certain areas of the state you're talking about a whole different issue, and that is a complete lack of the ability to get medical care.

Workers whose case is delayed or denied may face particular difficulties in accessing care. These workers must often find a provider who is not only willing to treat workers' compensation patients, but to do so on a lien basis—a yet smaller pool of available providers.

Information/assistance officer…There aren't any doctors in Bakersfield that would do a lien. We have a shortage of doctors and they don't want to have to wait for payment and because of all the report writing.

Attorney…the problem comes up when, on an industrial basis, their claim may be denied, or they've been discharged after a few sessions, within a week or two after injury, and the question then comes to me as to, "Where do I go to get medical care?"

Physician…I've seen more cases over the last five years where both the employer and I felt the problem was work-related, the case was still under delay. Why?

Physician…We've got to convince them that it's okay for us to see this patient three more times while they go through this delay process.

Physician…we do not take liens, that's the corporate policy…you know that this guy's telling the truth and the only reason it's on delay is he didn't report it for 15 days.

Physician…number one on the list [of problems] is this idea of somehow, for some reason, stopping medical treatment on the claims and letting everything jerk to a halt. And it just seems so counter-intuitive, and not productive for the patient…for some reason it's put on delay, like more and more commonly for reasons I don't understand, but we can't get the MRI, we can't get diagnostics…You want to get the nerve conduction and you can't do it, and the person's off work and off work…I just don't think it does the patient any good either, it just completely dissolves that trust issue.

Even workers with health insurance may have access problems if their health insurer refuses to cover work-related injuries, or if they lose insurance coverage due to being off work.

Physicians and others gave a number of reasons for the unwillingness of some providers to participate in the workers' compensation system—too much paperwork, billing disputes, concerns about legal aspects of workers' compensation, and other problems seen as worse in workers' compensation than in the general managed care environment.

Judge…In the same time it takes to see a workers' comp person, do the dictation, have it typed, have it proofread, under penalty of perjury signed by the doctor and all that, they could have seen 20 people for Blue Cross. And Blue Cross doesn't require all that report writing.

Nurse case manager…They don't want the paperwork. They don't want the headache and the requirements and, yet, they can be an excellent doctor.

Physician…I think we're now having more difficulty than people with private health care managed care, getting authorization for things like physical therapy, specialist referrals, MRIs.

The need to have access to care 24 hours a day was also raised.

Employer…One of the complaints we receive from injured workers is the availability. We have people working 24 hours.

Appropriateness of treatment: The focus groups held different perspectives on the appropriateness of care for injured workers, and on related issues regarding the utilization review process for authorization of treatments.

Claims adjusters and employers were most often troubled by ongoing treatment—especially passive physical therapy modalities and chiropractic care—in the face of minimal improvement in status or work function. These groups viewed such treatment as contributing to workers' disablement.

Employer…it's Dr. "Feelgood," and I won't mention his name right now. But I would be happy to tell you who that doctor is at any time that you wish to know. So you could just go to him and just get any kind of—any kind of note you want. And he will treat you for anything from cancer to psyche to you name it, you got it.

Claims adjuster…Is it appropriate treatment? This person has been receiving chiropractic manipulations three times a week for six months and they're not doing any better.

Employer…especially chiropractors, they give the hands-on good feeling treatment. You may feel good for 10 minutes but then they're back to the way they were but they know as soon as they come back in two days, they're going to feel better again for another couple of hours so it just keeps them coming back.

Claims adjuster…The last thing you want them to do is have a herniated disk and have the chiro pop you left and right, and they think oh, they're getting the greatest care in the world. And there's not a thing you can do. The only thing you can actually hope for is to upset this person that he'll go to an attorney that's halfway reasonable that you can try to get the right kind of treatment.

Claims adjuster…What's scariest to me is a chiro can be the treater and you'll see all these things and you'll be begging the chiro—send an MRI. Please, just…see an ortho. Please do some—and they won't refer them and it's just so frustrating.

Claims adjuster…Certain doctors in certain cities—okay, well, you're going to have surgery. You might as well call this claimant up—you're going to have surgery. I'm going to put the money up right now because I guarantee you—another doctor he's going to see you about three times and that will be about it no matter what's wrong with it. So it's almost kind of predictable.

Claims adjuster…many people get this palette of care that this physical therapy with—they never get active, they never have any rehab. They just get a year or two of passive modality therapy. I don't think that's quality of care, not just from the cost perspective but because of the whole person, they become real dependent and never get back to work.

Nurse case manager…Doctors don't have the time to monitor physical therapy and if we're not watching—like you say—all of a sudden you find out, my golly, they've had a hundred visits in physical therapy and they're still not back to work and they're no better. It just gets lost. It just keeps on going.

Claims adjuster…Certainly, the fact that there's no cap…The cost issue is so totally different than an HMO where there's no incentive…individual doctors have no incentive to hold down the costs of the claim at all, so I think that has an impact on what they do.

Nurse case manager…Because that's my concern right now about the medical treatment, which has become so excessive, so excessive. We can't say anything anymore. And it's so frustrating with the insurance company so my thing about case manager and talking to the doctors is when enough is enough, doctor? All these tests are negative. There's nothing but subjective complaints. You've been treating them for six months. The job is sedentary, why can't they work?

Employer…claims examiners will authorize surgery simply because, "Let's get it over with, so we can get the claim closer to the end."

Physician…I don't go for some of the things that I think are not geared towards improving their medical condition and then getting them back towards functional work…I see some of these people have been going to chiropractors for years, and acupuncture for years, and I just don't know.

On the other hand, there were concerns about underuse of appropriate care.

Claims adjuster…There's also cases where people aren't getting enough. They are really getting the doc-in-the-box treatment and told to come back in a week, and come back in a week.

Claims adjuster…There's under-treatment, too, in worker's comp.

Employer quoting injured worker…probably the [other] thing is, "They didn't do anything for me. They just told me to take a bunch of pills."

Claims adjuster…To be fair, it's not just the over-utilization by the chiropractor…It's the ones where they're treating and they're seen every two months…They don't see people except maybe once every two months and that's just as dangerous as the over-treating by the chiropractors, especially if they're off work, because there's nothing going on.

Injured worker…He [the doctor] wants to do surgery. I go to court, I said, "Can I have a second opinion?" The fact that I got three—one on my own—all three were…unanimously strongly opposed to the surgery that this orthopedic surgeon was proposing, which was to fuse the disc from part of my hip. They all said that it was going to fail…So I had to reject him as my treating physician because three other opinions say, "No, don't do that!" So you have to keep going through these things, you have to get second opinions and at the beginning there was no way to do research.

Injured worker…They keep giving me so much stuff, I started bleeding. I had to have two surgeries in my stomach.

Claims adjuster…It's specific and it's a serious injury and they go and they change treaters to a doctor that you know is going to give them the three treatments and on the third one—and they're all two months apart—the third one, you're definitely going to be P&S and that's it. And the patient is going to be worse off. He's not going to understand. He's still going to have that pain but all of a sudden he's P&S.

Claims adjuster…Whereas if maybe he had gotten the appropriate treatment he wouldn't be at that pain program at the end. And that's frustrating because I can't explain that or can't relay that to them.

Use of narcotic medications is a special concern. Nurses and employers gave examples of workers who have become addicted to pain medications.

Workers derided physicians who prescribed narcotics and told them to return to work at jobs that require driving or heavy equipment operation. Workers also expressed concern about inadequate pain management or being cut off pain medications precipitously.

Employer…The biggest problems of the attorney not getting involved…is when there's a pharmacy addiction problem—and we have that a lot—where we try to work through the attorney, say, "Hey, your client is getting addicted.

Employer…[In order to avoid] seeing them strung out for three years on Vicodin and their lives ruined…ruined, without the ability to do anything…So the worst cases I've seen are those where the people…one comes to mind that was a '96 claim I had a lengthy discussion with the adjuster about two days ago and it's a guy that had a hernia repair, about as minor a surgery as you can have, ain't going to hurt you. And since that time, he's complained of tremendous pain for, what's that, four years now? He's gone through pain management, he's gone to as many possible specialists as you can think of, none of whom have been able to diagnose the source of his pain, and I can only tell you from a brief review of his records that pain management concluded that the man should not be on Vicodin and he's on Vicodin, 'cause somebody's out there prescribing it for him. So he's strung out, and that's evil. That's just plain evil. So our HCO prevents that by making sure the person gets prompt…appropriate and necessary care.

Judge…I had an injured worker who was a recovering drug addict, and she wanted a TENS unit, but they wanted to prescribe the Vicodin, they would pay for Vicodin for her, but they wouldn't give her a TENS unit. And she had been in a drug rehab three times, and she was really trying to stay out of the drug scene. But they wanted to just give her some more medication…It's cheaper.

Nurse case manager…I have a concern about ongoing pain management. I think that I'm running into a lot of problems where it seems like the pain management gets inappropriate.

Nurse case manager…I also see that there are doctors that are scary. When you have a person that overdoes on medication that a doctor gave them and they have to go to a hospital to be detoxed. When they get detoxed, they go wow! Where have two years of my life gone because I didn't know anything. I've been in a haze. That's pretty scary and it doesn't say very much for your pain management.

Injured worker…I can't go back to work, I drive a truck…with a clutch. I'm taking Vicodin pills, pain pills and I'm on the highway…I'm not going to do it.

Physician…if you look at patients treated in urgent care centers or ERs for the initial visits for back strain or something else, vs. people who are seen initially in an occupational medicine clinic, you'll find more controlled substances prescribed [laughter] in the ER or urgent care centers. Absolutely guarantee that.

Injured worker…They stopped my prescriptions…they're not something that you can just …cut off, and that's what they did to me. And I'd like to see something in the system where they can't do that. I mean, it's bad enough that you have to wait for approval for a specialist, but if you're okayed to take certain medicines and the insurance companies are paying for months or years, and all of a sudden they arbitrarily stop…I mean, to put a patient through withdrawals, I think, is utterly cruel and senseless and there's no—and not to even have any medical basis for it.

The use of alternative and complementary therapies is also particularly contentious.

Nurse case manager…In California alternative and complementary therapies, it's a trend that's not going to go away so we may as well figure out how it can be incorporated in the most efficient way.

Nurse case manager…so you have to have an open mind and so when we're talking about quality of care and workers' comp, you have all these emerging disciplines that has to somehow be integrated.

Nurse case manager…we get a lot of question on unusual care. Because we don't channel care we get lots of weird, weird care. [Laughter] There's lots of questions about unusual, new, emerging technology.

Utilization review: Physicians, workers, attorneys, judges and nurse case managers complained of problems with the utilization review process for authorization of recommended treatment, specialist referral or diagnostic testing. Disputes over treatment are reportedly common.

While physicians say that the utilization review process affords some protections, they report that the process too often is simply ignored by claims administrators who continue to insert themselves into the authorization process in spite of regulatory requirements for physician review. Physicians and workers also report that many requests for authorization languish for weeks without response, or that no response is received.

Attorney…But they all have a problem with the authorization, the fact that medical decisions are not being made by medical people. And I think that's the biggest problem, whether it's workers' comp or outside workers' comp. When a doctor has to explain to somebody who just barely graduated high school why this is medically necessary, there's something wrong with our system. And unfortunately, the answer is often, "All right. We will file a Petition for Penalties. We will file for an expedited hearing. We will do something in the judicial arena, in a sense, because the medical side hasn't been able to do it."

Injured worker…the insurance company is the one who's making the decisions, not the doctors.

Injured worker…So who's the doctors? Is the insurance company or the doctor?

Physician…And don't you feel that the majority of times when they're put on delay, they're put on delay by someone who didn't even finish a high school education when you talk to them.

Attorney…I know that there's a mechanism in the administrative rules, etcetera, for getting decisions made, but I don't think they're followed…So it might be fine on paper, but in actuality I don't think we're getting things done.

Injured worker…the insurance company denied something like 14 treatments just because it wasn't expedient for them to pay for it. And this has happened to me this entire year that I've been injured. I go to see a physician, a physician recommends a course of treatment, and then it turns around, the insurance company denies it. And it's—there should be tougher regulations on the insurance companies that carry workman's compensation insurance.

Injured worker…if the insurance companies have the freedom to deny what the doctor requests, what is the workers' comp agency doing about it? And they should be doing something significant to change that kind of denial of care that I certainly have experienced to a very significant extent.

Physician…all of the restrictions and authorizations, has probably driven the cost up easily 15–20 percent, on average, per claim.

Attorney…the second wish I would have, among many others, would be that the utilization guidelines would actually work. But they don't! They don't follow them. The poor treating doctor, whoever he is, requests a MRI because the guy's knee is as big as a balloon, and nothing happens! He requests it again. Third visit. Nothing happens! The adjuster doesn't respond. Well, by that time, the doctor's maybe—in our area, he's whispering, "Maybe you should see a lawyer."

Attorneys…Most doctors will not authorize a procedure—will do a procedure that they recommend, until they hear from an adjuster, saying, "We'll pay them." There's some that do it—very few—on a lien basis. Even if you have an order from the Board, ordering payment, they won't do until they actually hear from the guy with the money. The reason is the lack of confidence in the utilization review system.

Delays in authorization are a very significant concern.

Physician…from the point of view of the injured worker, care delayed is frequently care denied.

Attorney…there's a delay in terms of getting to a specialist right away. When someone is told that it will be 3–4 weeks before the MRI can be performed, in the meantime the only thing they're given is some Tylenol, that's upsetting.

Claims adjuster…We need to be prompt on getting things done because we can help control that medical care.

Physician…if you lay out a clear line of logic as to why something should be done, it should not take the better part of a week to get a response from the claims examiner…Person has had three episodes of true giving way in the last week. Why does it take a claims examiner to take a week to give you authorization? Or even better, you get the MRI, the meniscus is torn, and then it takes several days to get authorization to set up the orthopedic referral.

Judge…in the cases that I wind up seeing, you look back on it and you think, "My God, why didn't they just authorize the…MRI a year and a half ago and find out what's wrong? You extended the TD period for a year and a half," and you just wonder…the wisdom of the adjusting approach.

Injured worker…with regard to the actual medical care, there's too much red tape…If you have a more serious injury, it takes a long time before you can see a specialist…you cannot get any immediate action unless you have an attorney, and that doesn't even guarantee anything.

Judge…it seems that there are many instances of interference by adjusters leading to delay, providing care that the doctor wants to provide…you have to come up with some way to provide incentives of some sort to speed the process to a legitimate level that you—to speed it up so that these authorizations.

Nurse case manager…we were all talking about doctors or the attorneys, we have to also focus on ourselves. How often do you as a doctor call up with a request and it sits in one of the examiner's phone queues on their answering machine for three days before you hear about it. How quickly do we respond because very often I think one of the big problems for an injured worker is they're sitting there and waiting. Doctor told me three days ago I need an MRI. I'm still waiting to hear about when that's scheduled. Very often a week later they haven't. Quality of care also starts at home. We need to work on turnaround time. Getting those responses back to doctors when they finally get around to calling us.

Of particular note are the perceived difficulties with denial of referrals for psychological or psychiatric treatment for depression, a problem also addressed by employers. Even when physicians or nurse case managers recognize that such referrals may significantly improve case outcome, claims adjusters often seem reluctant to approve for fear of accepting liability for a stress claim.

Nurse case manager…"Treat depression." That's one of my major concerns. And the second one, finding good doctors in a way that doesn't rely on people's biases and prejudices. Even when they say ask somebody else, ask your colleagues. I do but they say oh, don't go to him. He's terrible. And that's all I've got to work on.

Nurse case manager…I can tell when I'm talking to an injured worker whether they're suffering from depression and if they are it's a clinical treatable illness—that if they have that, then a lot of the rest of this that you do isn't going to make a lot of difference. They aren't going to be empowered no matter how much information you give because they've got this untreated thing.

Attorneys talking in conversation…

I'm saying, my client's out of work three months. He and his wife are bickering, they're kicking the dog when they get home, the kids are in turmoil, they can't put food on the table. I mean, let him talk to a neutral party…ten visits with a mental health professional, with new admission of psychiatric injury, something, just so they can get out of that cycle that produces the pain, that helps exacerbate the pain syndrome…Some of these people don't get competent mental health treatment for two or three years until we get involved and mount a huge fight.

…Or until they attempt suicide.

…Until they're divorced and… it's terrible.

Employers, adjusters and nurse case managers saw few remedies available for the problems of inappropriate or prolonged treatment. They were skeptical of the usefulness of the Employer Petition to Change treating physician, and of seeking recourse through the WCAB.

Judge…for the most part, where there's a conflict, if the applicant takes the stand and basically describes continuing medical problems and a doctor wants to do something, I think our liberal interpretation is, you grant the medical treatment.

Employer…it's nice that the employee can go to the QME if they disagree with the treating doctor, but the employer, we have no one to go to, and that's the part that's really unfair and it's costing us a tremendous amount of money. We're forced to litigate simply because a doctor didn't know how to write a report or we have a "Dr. Feelgood."

Employer…It's a very terrible, frustrating feeling, because I know they're not getting the quality care that they need. And people die. There's not a lot I can do. If they choose to go to that doctor, they're not going to believe me…and all you're getting is notes or poor written reports with the same rubber stamp on it all the time—the only thing I can really do is send them to another doctor and make them go and then you have to very politely send those reports to that "Dr. Feelgood" treating doctor and say, "This is the opinion that we have over here. He doesn't think you should blah, blah, blah. What do you think?" All you can do is very politely offer that.

Employer…I think we would be very remiss if we did not at least make that attempt, in many cases, and perhaps the saddest situations that I have to confront and that cause me the most pain are the very situations that you're talking about, where you have treatment that you know is absolutely harmful to this person and you can't stop it. And I don't know what the recourse is. And then the—where there isn't an HCO place, the work comp judge, who has absolutely no medical training, and nothing to rely on but paper in front of him—perhaps not even a CV—to determine the weight that should be given to the qualifications of the physicians who render the reports, how could you make this absolutely crucial decision, and how intelligent is that kind of a process? I mean that's about as insane as it can be and it never—it doesn't happen in civil court. It doesn't happen anywhere else! That is perhaps something that really needs to be changed.

While some judges feel comfortable about making medical treatment decisions, others are less so.

Judge…how comfortable do we feel? This doctor says yes, this doctor says no, I pull out a quarter and flip it. I'm not—what do I know about some medical procedure? No, oftentimes I feel very uncomfortable.

Judge…And I wish the parties had done a little bit more to develop the record, but the applicant's with some treater who likes to try all these interesting things and the applicant's attorney doesn't want to really change it, because he or she thinks it's legally to their benefit to stay with this guy who's going to keep the applicant on TD for a long time and—so I'm not so sure, sometimes, that the treatment that's being suggested by the treater is really appropriate. Your question's a good one. How good do we feel about it? Oftentimes not all that good, but—other than training judges more about medical stuff, I don't know what you can do about that. It's just—you end up looking for a weakness one way or the other, legally…but then you might be feeling like, "Maybe that's not a very good decision, because I'm not concerned that's the just outcome"…in the old days, they could refer people to the Medical Bureau.

Judge…It would be nice if we were all online and we had some access to a medical… where we could go—there's some weird procedure, we could click in and find it and at least get some basic description of what the hell this is.

Judge…'Cause I'm uncomfortable, as a lay person, to make a medical determination, even though I might have a personal view about the nature of a certain injury, or even in weighing the credibility of witnesses about what their subjective levels of pain are or what the employer perceives the employee to be doing on the job.

Judge…I'm relying a lot on the treating—if the treating physician comes in and says, "This is something that's necessarily, that's reasonable, this is going to cure or relieve the effects of the injury," and I got a defendant who's got a QME that says something…under the Labor Code…the treating physician is entitled to presumption.

Judge…the duty to develop the record is contra to the duty to close discovery. So you close discovery and then you got a crappy record and then you're making a finding for the presumption on some scribble on a prescription pad [laughter] that says TTD.

Payors were also unhappy that the utilization review record is not admissible before the appeals board, so that even an evidence-based UR decision may not influence a judge's determination.

Judge…The reports of the medical review committee were not admissible. 'Cause they hadn't examined the patient. The adjuster had denied the procedure based on the utilization review committee and then it came in to me in an expedited hearing later and [laughter] the insurance company had no evidence, no admissible evidence. Now, the utilization review committee could have been right! But they lose [laughter]!

Just as payors expressed frustration over their perceived lack of remedies for excessive treatment, the other side voiced the same frustration with remedies lacking for delays or denial of authorization for treatment.

Injured worker…Expedited hearings are one way for the injured workers to get the medical treatment on an expedited basis. But it seems that the WCAB and the DWC is trying to dissuade injured workers from filing for expedited hearings, and I'd like to know how and why…[What is needed] is a stop-gap measure to get some modicum of medical treatment, if needed.

Injured worker…if you try to challenge it in court it takes almost three—two or three months just to get it heard.

Judge…I think there's a disincentive for applicants' attorney to ask for expedited hearings. They would rather—yeah, they would rather collect the issues and have one big hearing at the end.

Judge…See, we can remedy these improper delays, but it takes time. They have to file, they have to get it on calendar, then make a decision, if they—the insurance company really wants to play hardball, they can appeal it.

Knowledge of workers' compensation system: Every group complained about physicians who are unfamiliar with the workers' compensation system, and acknowledged the need for more treating physician training on workers' compensation issues.

Employer…You can be the greatest treater in the world, but if you can't follow the guidelines as set forth in workers' comp—write the reports timely, communicate with the adjuster, communicate with the employee and the employer—we can't use you. And that's the bottom line.

Employer…a lot of these doctors just don't know, they don't understand. And they're great treaters, so what we had to do is get the balance where they could actually meet the guidelines. I do think they do need, overall, just a little bit more training and timeliness, and I don't think it's something they just don't want to do. They don't know where to go, or they don't realize the importance of the whole picture.

Employer…Good quality care is great, but you need that P&S report, you need the PR2s, you need them to tell you, do they need to go see a specialist. You don't want them to just sit out there and just hold their hand.

Employer…And most docs don't know how to do that, and it's not that they aren't capable, it's just a fact they don't know.

Employer…the doctor's first report. I don't know how many private doctors are even aware of that report that's required to be filled out by them even to begin to treat workman's comp.

Judge…so we get to make a decision on a real crappy record. That's what we get to do. We're making decisions, now, on a record that stinks …much of the time. 'Cause the treating doctors that we see—even if they're excellent doctors—really don't know how to write a report.

Judge…hear from injured workers, oftentimes, is that when they go to the employer's medical provider, that initial clinician really may not know what they do as an occupation.

Judge…a lot of times, when you see doctors who really treat well and the people are happy with the results, what I've seen, many times, they can't write a report.

Nurse case manager…we have an awful lot of providers out there that they go off to on their own that have no clue about the occupational provider sector of it and how to work with getting people back to work. It's just totally foreign to them.

Physician…Kaiser really is pushing improving the quality of its physicians…but a large part of the push has been to get the physicians more sophisticated in terms of how to navigate their way and the patients' way through the workers' comp system.

Physician…the guys who go through the occ med programs at schools and when they take the boards and they're the most qualified, most educated, are not practicing occ med, they're out doing their research studies. And the people who are coming into occ med are people who come from internal medicine, maybe background or family practice—an awful lot of ER burnouts come into occ med [laughter]—and urgent care burnouts.

Physician…There are very few people I know in primary care who can do what I do. They just don't do it right.

Return to work (RTW): RTW was a major topic of discussion in all of the focus groups. There was unanimous agreement that attention to functional and return to work outcomes is a critical aspect of quality of care for work injuries.

Workers and employers emphasized the importance of having a doctor who understood the specific nature of the worker's job, and the impact of the injury on their functional and work capacities.

Several groups identified the lack of useful, user-friendly information on return to work—for attorneys, workers and employers—as an impediment to improving return to work outcomes.

Judge…the goals of the occupational health clinic and injured worker sort of divert from each other. The injured worker wants the best care possible, and…the occupational health clinic, the goal is to get the worker back to work as soon as possible.

Judge…You have adjusters calling doctors, "Get this person back to work." And you have applicants' attorneys saying, "Well, you can't cure him completely, 'cause he won't get anything at the end of his case…" You get influenced in this system by outside forces.

Employer…We also have a return-to-work program so that virtually, we can, within our system, bring back every person, unless the doctor wants them flat on their back in bed. We can find a place.

Attorney…the other side picks doctors to minimize the disability. I don't think there's any question about that, from our experience, that these so-called industrial clinics are designed to get the person back to work at any cost, especially the cost of their health.

Employer…They've seen their physician who says, "I think you can work, as long as you don't stand all day long," or whatever, and they don't want to work anymore. They want you to take them off work, and an attorney's going to promise them, "Okay, I'll send you to somebody that will take you off work.

Attorney…these places, these company clinics have a board that says, "If you work for [name of company], no temporary disability.

Attorney…So you're in a coma and, "Modified work is always available." What are the man's restrictions? He can be a doorstop. [laughter]

Employer…people really want to come back to work for the city, they really like their jobs, especially in those two departments [police and fire], that's their career.

Employer…they were referred down to another doctor, who says, "Oh, you got a bad back. Okay, take a couple of days off."

Employer…I think the role of the physician is to provide the employer what an injured worker can do, and it's the responsibility of the employer to accommodate that capability. And if the employer cannot find accommodation for those restrictions, then I think that would be the point that the employee will be placed on temporary disability. And make it clear to the injured worker that it's not their physician who's going to make that decision but it will be their employer. So that there is that expectation on the part of the employee that, "You're being treated so that you will get better and come back to work, not treated so you will be off work."

Employer…some of the physicians who, even though they're not dedicated comp physicians, they are a patient advocate and they like their patient, they have a developed a good rapport, especially if they've been their personal doctor a long time. And when their patient comes in and tells them, "I still don't feel good," they empathize with this patient and they say—a lot of times, they'll say, "Well, what do you want me to do?"…because [the patient] will say, "Well, I really don't feel like going to work yet." And the physician will say, "Okay, fine. You're off work"…when really, there is, medically, no objective findings to give this employee off work, and it's just because of that relationship, also. And again, there is no motivation on the part of the physician to…this patient back to work. And a lot of times, physicians, they—I've been in doctors' offices, they are—every 15 minutes, they have to see a patient. They do not have the time to explain to the patient why they can go back to work, or what they can do and what they can't do, because they are pressured by time themselves, and that is not their focus, their focus is to get this person healed, it's not back to work. So the physicians are not—may need some more education on that part, also.

Nurse case manager…A lot of them [doctors] have trouble with the issue of modified and limitations of what that person can return to. So they won't, they just avoid doing a report or giving an answer.

Nurse case manager…they were going to say that John Doe, here, we don't want him. He got hurt, thank goodness! Now, we've got a way to get rid of him. If I know that up front, then I know how to channel what I need to do.

Physician…if there was good-outcome studies on return-to-work date and things like that.

Timing of RTW: There were significant differences in perspective about RTW timing. Some workers, nurses and judges were concerned that the company doctor was pushing workers back to work too soon, or without adequate protections from re-injury. Other workers relayed fears about staying off work too long, and the resultant risk of losing their job or being unable to provide for their families.

On the other hand, several employers, claims adjusters and nurses were concerned that physicians—both those unfamiliar with occupational medicine and applicants' doctors—encourage disability through inappropriate delays in releasing injured workers to return to work.

There was consensus among the physicians and nurses that early return to normal activity, including work, facilitates improved outcomes, particularly for workers with musculoskeletal injuries. Physicians also recognize the potential for re-injury or delayed healing if RTW is handled inappropriately.

Workers, judges and applicants' attorneys were far more concerned that early RTW risks re-injury, poor healing and increased pain. Workers raised specific fears about re-injury and working when they were still in pain. Some employers, adjusters and nurse case managers believe that applicants' attorneys may prolong time off work to maximize the benefit settlement.

Attorney...we've seen so many cases of people who return back to work way too soon and suffer further exacerbations or further injury, that…unfortunately, the amount that someone will get on disability just doesn't compare to what they would get if they were back to work and working healthy and full-time.

Injured workers...There's a rush to get people back to work too soon. [general agreement] [various voices]…And to not place any limitations…And you go back and get re-injured.

Judge…if you have the insurance company who originally provides the treatment, the guy is returned far sooner…if it's a doctor outside who's been selected by the applicants' attorney, then he's treated much longer.

Nurse case manager…Some doctors I know that if a patient goes to that doctor, that patient will not go back to work for a year.

Judge…I've seen cases…where you had the employer contacting the health clinic and saying, "When can we expect this person back to work? Is there anything you can do to release this person back to some modified duty?" And if he doesn't come back to work because he doesn't feel like he can, then he's fired.

Employer…I have read that in the reports: "Applicant indicates that in three weeks he'll be able to return to work [laughter]." Wait a minute. Excuse me? Hello? Who's the doctor here?

All groups identified similar problems relating to the availability and nature of work restrictions on return to work:

• Many physicians lack knowledge about what work restrictions are appropriate; others fail to

prescribe any work restrictions. Physicians also may have difficulty obtaining a job description from the employer, or may get conflicting descriptions from the worker and the employer.

• Employers often fail to provide modified work at all, and require that the worker be one hundred percent fit before returning to work. Some employers claim that modified work is available, but subsequently require the worker to exceed recommended work restrictions after return to work.

• Some workers and physicians felt that physician follow-up after release to return to work is inadequate, failing to recognize problems such as "creeping" work restrictions.

Claims adjuster…we like to get the doctors into the customers, and say, come see what our customer does. You know what? That helps, that does help improve care for the injured worker, because the doctor or if the staff has gone over and sees the facility, sees how it operates, somebody comes in and says, oh, you know I work on this punch press, I do this, they go, I know what you do and I know what I'm going to have to, what you have to do to be able to get back to work.

Nurse case manager…[what] I find myself doing more and more is finding out about the employee's job, getting a job description, taking that to the doctor so that the doctor can realistically say early on: Can this person go back to this job or is it out of the question?

Injured worker…Actually, my treating physician has done an excellent job with assessing my work skills, what I need to do, what's required for me to be up to moving…and he's written letters three times to my employer, requesting that these accommodations be made for me…every letter that he has sent in has been completely ignored, and so I'm in a position where I'm expected to do my job as if I had never had an injury.

Injured worker…I know in my situation…so I went back to work thinking if I worked a little harder that the pain would go away. As the result, three months later, it came to the point where I couldn't even feel my pinkie anymore. And I feel that had I had good, competent care, somebody who understood my duties as a probation officer, not only in report writing but in all the physical things that I have to do which put me at risk, if they had understood that and they had scaled back and limited my duties at that point, I wouldn't have injured myself to the point that I did.

Physician…knowing exactly what they do at work and intervening when appropriate—ordering work station evaluations, advocating for the patient when whatever party is responsible is dragging their feet with regard to making the appropriate changes. If you put somebody back to modified work with keyboard restrictions or mouse restrictions or whatever, and the equipment isn't there, then nobody wins. So I think that's unique, it's an integral part of their care to make sure that the interface with their work station is as ergonomically sound as possible, and that takes a lot of energy.

Injured worker…one of my concerns too [is]… the employer adhering with the medical limitations. Sometimes a doctor really has no other power except to take the injured worker out of work if the employer is not complying. And in my situation, and probably many others, people want to remain productive, they want to feel like they still have some control over their lives and they can work. Certainly, there should be something more that a doctor can do, besides just taking somebody out of work. I mean, we should be able to get the employer to comply with the medical limitations.

Injured worker…But after the third time that I went through working a modified job that was inappropriate, my doctor realized that my employer was not doing right by me and as a result, I've gotten worse. But in my case, luckily, I had a supportive doctor with regard to that. But there's a lot of doctors that aren't going to stand up to an employer, and that's unfortunate. 'Cause it just hurts the injured worker worse and then they're off work longer and, you know.

Injured worker…"We don't have any modified job." So they put me to work in a job—the doctor says I should not—please don't bend or stand up for a long time. They put me in a job where I have to twist, to bend all the time and I have to stand up in 2 x 2, a little pad on the door, and so I asked for the chair to sit down, they deny even a chair, said, "Your job is to stand up and greet every customer with a smile." I cannot smile.

Judge…You have a situation where the doctor at the clinic releases him to modified work and then he goes back and he does modified work for 15 minutes and then they say, "If you want to keep working, you'd better get over there and start humping those bales.

Nurse case manager…The supervisory component at the employers is so key because if they send someone back with restrictions and then the supervisor isn't diligent or is putting on pressure for this person to be performing all of the job tasks that are really outside of the restrictions, so they play a huge part in the follow-up.

Physician…We all have had many experiences where we send them back with a 5-pound maximum lift, no repetitive bending or something very reasonable and they're doing their regular job because there's nobody else there to do it. That doesn't work, so I always tell them yes, I think they're better off at work for a number of reasons but if they're going into a situation where they're going to hurt themselves, that doesn't—nobody wants that.

Injured worker…my employer put me back to work doing exactly the same thing. It exacerbated the injury, made it worse. I went back and saw an orthopedic surgeon. He put me off work. I've been off work ever since then. My employer says they have no type of modified work that I could do. I still haven't been terminated, but there is nothing I could.

Injured worker…Three weeks after my accident, the doctor sent me back to work, and when I reported to work, they told me, "We cannot put you to work because we cannot obey by the restrictions of the doctor."

Injured worker…then the doctors come telling me that, "Well, you can go back to work and you can have a sit-down job, you can stand up for an hour or two, 30 minutes at a time and whatever. The company I work for, it's only three truck drivers—the boss, two truck drivers and me, that's it…So you don't have any sit-down jobs…So I've been off of work since October 11, last year.

Injured worker…If I feel that I can't be at work, it should be my choice, it shouldn't be up to anybody else.

Injured workers expressed considerable fear of re-injury. They also raised concerns about side-effects of medication—such as drowsiness, lost productivity, fatigue—on their return to work efforts.

Injured worker…And now they're saying that they're going to rotate and that means I have to go out and deliver mail on campus. And that's a lot of hard work and stepping up into a van and kneeling into the van and getting the mail out and it's heavy work. And I know I can't do it…It's just going to mess up my knee and I don't want to have surgery on my knee. If I stay off, do what I'm doing now, it's fine.

Injured worker…And he put me on modified work not using my right hand or right wrist at all. And my manager instructed me to go back to work, and I've been doing the same job with my left, and I'm right-handed. And I keep on complaining that I started having problems with my left hand. And now I am only using my left hand. But they don't want to hear that. He doesn't want to hear, the doctor. So I'm doing almost all my work with the left hand…I'm afraid that I'm going to end up with the same with the other hand.

Expectations and outcomes: Many participants felt that workers had unrealistic expectations regarding the possibility of full recovery. These unrealistic expectations were attributed primarily to inadequate patient education and lack of knowledge of the workers' compensation system.

Claims adjuster…I think a lot of claimants… anticipate that they will go back to 100 percent of what they were prior to their industrial injury and there's so many times you have to explain to the claimant that that's not true …sometimes they go into the doctor's office expecting God's there, he's going to repair me and I'm going to be 100 percent back to normal. I think there's a philosophy that if I have surgery, I'm going to be back to normal and they don't realize that that isn't always true.

Nurse case manager…there's so many times when they are set up for failure from the beginning with expecting a complete cure really from and I think that in a real world that's not what happens with most injured workers.

Nurse case manager…So I think more outcome—like evaluation of pain management treatments, I think, is a huge issue for everybody—the spiritually wounded injured worker, how are they going to get relief in this cruel world? Is it going to be through a pain management clinic or what? Those kinds of outcomes would be very helpful for helping people make choices.

Nurse case manager…People should not be allowed to be in pain. That is a very important parameter of quality of care for me. None of this is going to show up on an outcome study unless you do these expensive—worker, how was your experience—type of interview.

Choice and control: While focus group participants viewed choice of physician as an important aspect of care in general health care, choice and medical control emerged as a major workers' compensation concern for all groups.

There is widespread recognition that the treating physician plays a role beyond treatment in the workers' compensation system, since physician decisions largely determine the receipt and amount of benefits. Workers, judges and applicants' attorneys decried the lack of worker knowledge about the right—or its significance—to predesignate a personal physician before entry into the workers' compensation system.

Employers, claims adjusters, nurse case managers and some physicians bemoaned their inability to maintain control over medical treatment, and the problems associated with workers or their attorneys selecting physicians with little knowledge of functionally-oriented occupational medical care or the workers' compensation system.

One employer, however, believed patient choice of physician is preferable to employer control.

> **Injured worker**…And the insurance company lied to me, told me I couldn't switch doctors, I was stuck with a surgeon who gave me totally inadequate post-operative care.
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> **Injured worker**…You want to go the expert, but—so a lot of it is just doing your own legwork. Unfortunately, you're not going to be sent to the best place. It's not going to happen.
>
> **Judge**…while they [workers] have a legal right to change the physicians…as a practical matter, they're not in a position to phone up ten doctors and say, "Now, which is the best."
>
> **Judge**…many adjusters don't know, they go by the Labor Code which, black and white, says one choice…they [adjusters] believe that there are no choices; that's it, absolute control. And I think people get attorneys, in my neck of the woods, because no one tells them they can change treating doctors and they're not satisfied with the quality of the care during the first 30 days. To me, that is the major reason for litigation.
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> **Attorney**…If you want quality care, you've got to eliminate employer control, you've got to eliminate this company clinic business.
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> **Attorney**…[to improve quality]…free choice of physician from day one and less non-medical administrative hangups to getting proper treatment.
>
> **Attorney**…You try to get them to somebody who'll treat them, who will treat them like a human being, who will treat them like a patient, who will not treat them like a chattel.
>
> **Judge**…it impacts on that quality of care…the defense doctor…he's under a lot of pressure to get them P&S within that first 30 days, and to give him whatever restrictions he's going to give them, because after—he knows on the 31st day there's going to be an election sent in for a change of treating physician. So therefore, in order for the defendants to maintain control and to have the reports they want, he's under pressure to make sure that the person is treated and out, if at all possible, by that particular time, regardless of what he may feel.
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> **Employer**…We do fine as long as we keep them in occupational medicine. It's when the employee swings out to their private—to one of their own physicians that we begin to lose them, because there's a different agenda once they swing out.
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> **Employer**…If you can keep control—if you can have a quality-care control for at least, I would say—and correct me if I'm wrong—the first six months—usually if they're going to get an attorney, it's going to happen, I believe, in the first six months. If he gets one in the first month, you know there's nothing you could have done to make it better, those people are just going to do it. But yeah, I would say 3–6 months, if you can really become proactive and work with the employee.
>
> **Employer**…We can actually pull the business away from them and go to a different clinic if they don't do the type of treatment we want, and one of—of course, one of my jobs is to watch them. They know I have an expectation within from 30 to 45 days if you don't see improvement, I expect our employee to be referred out to someone.
>
> **Employer**…That happens all the time, especially when they litigate and that's the bottom line. You might have them seeing the best subspecialist possible to treat a particular condition, and then they litigate and the attorney sends them to Joe so-and-so down the block …who's a general and—oh, you wouldn't have your dog be treated by that doctor. And that is—it's a crime. That's the major thing. You've done everything you can to help this person get the best care possible and then bam!

Nurse case manager…I'd like to extend the 30 days to 365. [laughter] No, I really do. I think it would improve the quality of care if the care was directed for a longer period of time.

Nurse case manager…doctors who probably wouldn't even have a practice out on their own, they're so poor quality—and so they're giving that as their treatment for their employees. So quality of care is atrocious and then to try and get them out of that situation is a real fight.

Physician…The way they…manage the control and management and oversight is very different because of the time they have allotted. The pressure we have from the employers—or especially insurance and adjusters—to try to get a resolution in 30 days continues to be there.

Employer…the one thing I like about if they have the right to treat with their doctor, I would think very few people just run to their doctor for frivolous complaints.

Employer…30-day control, which, as claims people, we don't want in our department, because we feel that we should establish relationships or communications with the physicians that we know are good and provide quality care, rather than have this adversarial role, and it's been—it's a long history.

Workers spoke of feeling confused by the large number of physicians they were required to see, often without explanation as to each one's role.

Nurse case manager…There's another thing that comes into play is like 30 days, who has medical control and who doesn't. Because at the point that as the case manager we lose medical control as soon as there's an attorney involved.

Medical-legal issues: Much discussion focused on legal aspects of the workers' compensation system that influence medical care delivery. All groups perceived legal issues as impediments to improving the quality of care for workers injured on the job.

Physician…It's not designed to be a care system, it's designed as a legal system. It was a compromise, in order to provide care and compensation for lost wages, on the one hand, to injured workers, and on the other hand to protect employers from ceaseless litigation. It was a legal compromise, and we're saddled with that.

Injured worker…I never thought about getting a lawyer. I thought I was going to get medical care. Why should I have to get a lawyer to get medical care?

All groups discussed workers being encouraged to switch doctors on the basis of legal rather than medical concerns. Physicians said with frustration that this impedes continuity and their ability to build the doctor-patient relationship.

Applicants' attorneys, while understanding the importance of continuity of care, emphasized their responsibility to explain clearly to clients that the treating physician affects the ultimate financial settlement for the worker.

Treating physician presumption: There was surprising consensus among all groups, except applicants' attorneys, that the treating physician presumption can have a very negative impact on quality of care. The presumption reportedly creates conflict between seeking or recommending treatment with a good treater as opposed to a good report writer.

Attorney…If my client happens to come into my office and, perchance, he has been referred to a sports medicine group that I know that treats, for instance, orthopedic injuries and gives good-quality care, I advise them to stay. I have to explain to them the question of the presumption of correctness in courts, because that's a choice that the client must make, whether they want to give up this particular competent orthopedic surgeon who writes minimal-type final reports or are they more interested in getting a good result financially.

Judge…I see applicants' attorneys who are relying on doctors that they never would have relied on before, because they're treating and the doctors say, "I'm continuing TD, TD, TD, TD, TD, TD" forever and you wonder about the treatment, but "from a legal standpoint I guess it's good." But then you wonder what's happening to this poor guy.

Employer…You may get a treating report that's two pages, says absolutely nothing, may be absolutely inaccurate, and then you've got a beautiful 12-page, top-notch report from the subspecialist who's preeminent in the field. And it's thrown out.

Physician…If somebody gets a primary treating physician, as it's defined, who has a vested interest in overutilization, it gets to be rather hard to rein it in. It really is. That's one of the downsides of the presumption of correctness.

Claims adjuster…that treating doctor's presumption of correctness, I think, sometimes are given too much because you can send in to a defense QME, who has a great reputation, but then when it comes to settlement…attorney argues doctor's presumption of correctness. But this report is garbage…I think sometimes you have to re-look at that law of treating doctor's presumption of correctness…you just have something that's totally off on some other planet that just came in from nowhere and you're stuck with it.

Judge…with the treating doctor's presumption you have a whole new phenomenon that takes place…the attorney who wants to control treatment is looking for a doctor to treat the applicant who is a good doctor but also who knows how to write a medical report from a legal standpoint, that's exactly what you want to do, because then you control treatment, you control the presumption, you essentially pick your own AME, and the other side is screwed although down south, they're very sophisticated—generally speaking, the doctors that the applicants' attorneys use are very good report writers…but you're not thinking about who is the best possible doctor to treat this person. You're thinking, "Who is going to write a good report"…So suddenly, the medical-legal concerns are wrapped up in the treatment concerns and it's a touchy situation…When you pull together with the presumption, the lawyer is in a bind. You can't do that anymore. You could be committing malpractice if you do that. On the other hand, if you are telling your client who to be treated by, by definition it's—to some extent at least—you're compromising the very best treatment. So you're put—the applicant's attorney, I think, is put in a terrible dilemma.

Judge…presumption of correctness of primary treating physicians…it's just a headache and a can of worms.

Judge…it's all politics, that's what the whole presumptive is about.

Judge…It's a legal fiction that has impacted and I think interferes with the quality of care, because it's foreign to medicine. There's no such thing as a presumption of correctness.

Judge…And so the presumption down here has been an invitation to manipulate the system by both sides. The defense community uses it to send them to their medical clinic—if the applicant doesn't get representation or know enough, he ends up with a defense doctor who washes him out of the system and the defense doesn't want to compromise the case because, "Oh, we had the presumptive doctor." And the other side of the coin…the applicants' bar…it's malpractice if you don't take control of medical treatment and send them to your doctor, and they have the same—so now their doctor can write whatever he wants and he has the presumption, and they don't want to compromise when they get down to court, so what it's done is created more litigation down here and has not made the system fairer. And very hard for judges, who are not doctors, to try to figure out who's fair and who's not.

Nurse case manager…Eliminate the primary treating physician's presumption of correctness. That very often is the biggest barrier to give the injured worker proper care. Get them to a doctor who is adamant about his position who is giving just completely wrong-headed care and you can't do anything about it.

Some participants expressed frustration over legal concepts not being rational from a medical standpoint. For example, some claims adjusters believe that permanent and stationary (P&S) or case closure suggests further treatment is unnecessary.

Physician…it is as if the[workers' compensation] model doesn't understand that there may be a chronic condition…and they come back for some kind of care, which is absolutely appropriate, you get a letter or a phone call or something from an adjuster or a nurse case manager, apparently amazed that this person, despite being P&S, could still have some problems.

Accountability: While many parties are involved in a workers' compensation case, no one in the system is clearly responsible or accountable for the quality of health care. In fact, when asked who is responsible for ensuring good quality of care, there was no consensus within or across groups, although in all groups the responsibility of the employer was mentioned.

Employer…arguably, the employee gets injured while working for the employer so the employer should have the initial responsibility of seeing that he gets good-quality care from the start. That doesn't always happen.

Judge…I think it's the injured workers' responsibility to select a physician that they feel can provide them with quality care. I think it's the insured's responsibility to make sure that that medical provider gets paid so that quality of care can continue.

Judge…whose responsibility is it? Well, it's everybody's. It's the injured workers, to try to figure their way through this, which they do. It's the injured workers' attorneys, to try to help them get the best treatment possible and put as much pressure as has to be brought to bear on the adjuster to do what the adjuster should do. It's the insurance companies, in terms of—I would think maybe, at least in clear cases, to authorize relatively inexpensive diagnostic procedures to move the case more quickly, to keep the PD down, hopefully, and the TD down, hopefully. It's employers, to want to learn from injuries that they have in their plant or their shop or whatever it is and if their employees are good employees, are not coming back, are not getting treated well, they're getting complaints, maybe they'll look at another insurance company. It's everybody's responsibility.

Nurse case managers talking in conversation…

Who do you think is responsible?

The employer. It all starts with the employer.

It starts with the HR people, it starts with the hiring process.

It starts with their internal safety programs.

Giving the applicant for the job a job description and making sure it fits with their functional abilities. It does start there.

…physicians are also responsible for quality of care, obviously. They have the legal responsibility.

Unlike the general health care system, there are no standardized performance measures which allow consumers and purchasers to make choices based on quality, or which allow health care providers to identify quality problems or to measure improvement.

Attorney…But if there could be better standards, to say, "Gee, there's something wrong with this case," and that's training of doctors, I guess.

Claims adjuster…A lot of time it seems like they [the clinics] rush these people in and out. There's really no accountability for whatever mistakes, or what they make.

Claims adjuster…There's no accountability on all sides, just on one. It's just the accountability for us to do our job perfectly in every single way and form, but anybody else on the other end that makes a mistake, oh, it's just a mistake. And, especially the doctors, they're the ones that are either going to…they're the ones that are providing the care, either make them better, or do something else for them. There's no accountability for them.

Physicians in particular voiced interest in receiving more useful feedback about quality of care, and willingness to be held accountable through performance measurement.

Physician…I've done what I've done, and I'm willing to be held accountable for it. I have to. I have a license to practice medicine…I've made the interventions that I've made, I've said the things that I've said, and…I should be willing to be accountable, to have that performance evaluated.

Physician…What you tend to hear is anecdotal or it's a complaint…That's not useful feedback either, there are problems that need to be taken care of and I wonder if there's a way to get at what's really important.

Physician…Well, that would be something, if you got the data that showed that dedicated occ med clinics, company-designated physicians, got better outcomes. I think—if you look at the data, I think that's what you're going to see, that company-designated providers by and large get better outcomes. They have fewer patients end up in voc rehab, fewer—lesser permanent disability, etcetera. I really believe that.

Individual organizations are making some efforts to evaluate the performance of providers or monitor their own performance. It is difficult to create standardized performance measures in areas where there may not be any benchmarks—for example, effective treatment to prevent disability.

Employer…We use our nurse, myself and the warehouse manager or whoever will go out to the clinic and we do our clinic review, and we make sure, number one, they meet our standards and they understand our return-to-work program, we leave them our job analysis book.

Employer…look at the clinics and we monitor the clinic's activities and hopefully—now when you're talking about smaller employers, it becomes more difficult, more distant. But I agree, they should be working with organizations that can help them network, as somebody mentioned earlier, to find good providers, good initial providers, 'cause that's really what boils down to.

Nurse case manager…what we do in terms of quality is we have URAC accreditation for both utilization review and case management of criteria setup and the results reviewed on a monthly basis, along with national meetings comparing everybody else's data and in-services.

Physicians…Kaiser expends significant resources monitoring patient satisfaction. As a matter of fact, they're called MPS scores, for…member-patient satisfaction…and they are a critical component in how we're going to be evaluated, as well as productivity.

Physician…what has made our practice of medicine in contemporary times better than it was, in a sense, in general terms it is research information. And perhaps as a part of quality of care, you might consider the ability to perhaps perform some research studies.

Physician…I guess the caveat is that it would be hard to imagine getting this information that wouldn't somehow be punitive.

Physician…I wonder if that information wouldn't be helpful in getting some idea and getting some consistency within occ med, statewide.

In sum, participants in all focus groups identified the major barriers to quality improvement in workers' compensation health care:

- Distrust
- Lack of knowledge and information
- Poor communication and coordination
- Treating physician presumption
- Lack of incentives for quality
- Lack of accountability

Focus group ideas for improvement

The groups were asked what could be done to improve the quality of care for injured workers in California's workers' compensation system "if they could wave a magic wand." Participants made literally dozens of recommendations.

Ideas for Improving the Quality of Care for Injured Workers

1. Provide more education/information about workers' compensation medical care.

2. Improve access to care for injured workers.

3. Increase accountability and use standardized performance measures.

4. Create incentives to promote quality and better outcomes.

5. Require certification for treating providers.

6. Improve return to work through assisted and required provision of work modifications.

7. Improve claims handling of medical issues.

8. Improve the utilization review process and provide for independent medical review.

9. Reduce disputes and litigation, provide more information and help for workers.

1 Provide more education/information about workers' compensation medical care. Improving the availability of useful, user-friendly information on medical care in the workers' compensation system was widely perceived as a relatively simple way to improve the quality of care for workers injured on the job.

Physicians and nurses recommended an Internet-based clearinghouse for easily locating resources—such as treatment guidelines, forms for physician reports, review articles on treatment of common occupational injuries.

Claims adjusters and employers also thought it would be useful to have better access to information on medical issues and return to work.

Workers repeatedly described the difficulty they have finding relevant information, and suggested that state government provide injured workers with information that is more easily understood than the benefit notices, and that addresses specific issues.

> **Employer**…have guidelines that physicians that are treating workers' comp either are taught to go through the system, how to treat an injured employee.
>
> **Employer**…And there hasn't been a place for them [doctors] to go to understand…but you need someone who really can walk through the process. And it's a shame, because those are some of our best treaters.
>
> **Employer**…before the discharge, set up a regular session where they say, "Okay, you're okay. This is how you're injured. This is the way you should be lifting. This is what you need to do to take care of yourself. Here's an action plan of doing certain exercises," as part of the discharge from any clinic. That would be wonderful.
>
> **Employer**…Maybe OSHA should put on these seminars once a month or something, and all—the community of employers send their employees to that as a mandatory couple-hour thing that they need to go visit.
>
> **Employer**…employees tend to listen more to the professional people than their own employers…But I really think it has to be done at the clinic discharge and it should be done by either a doctor or a physical therapist.
>
> **Employer**…I tell you what we lack. We lack education, and this has been forevermore… there is not enough education from the employer to the employee—and the union. I think that they—if there is a union involved, you have to involve the union…More communication with that, more education between the employer—what they have to offer for an injured worker and what the role of a physician is when it comes to treating an injured worker.
>
> **Employer**…we need judges who know what they're doing!

Employer…best thing I can think of is to figure out some way to generate some educational materials that you can mail to them [employers] on a semi-regular basis. You have 40,000 employers out there that are under 100 employees.

Employer…not only communication but better education between the physician and the employer so the physician understands his place in the particular system and how to coordinate with employer those situations when employer is capable of offering the modified job for the employee to do.

Employer…there is a big gap, still, in communication and training—training between the state and what is it that their position is, in regards to giving support to the employer—like she has indicated, education for the judges.

Judge…So that would be an excellent tool, if we had a neutral, up-to-date source of information about those typical costs.

Judge…one of the critical things in getting injured workers the best care is to make them informed consumers just like the rest of us, and so I think the point you made about the 30-day rule is really, really a critical point. I think if more injured workers knew about just that one little thing, it would pressure the system.

Injured worker…I think that there needs to be, by law, a template that is a patients' bill of rights under the workers' comp system. You have the right to choose a different doctor after 30 days. Patients don't know that…there should be a bill of right for patients that should be given to them at their date of injury: "These are your rights. These are the numbers you can call."

Nurse case manager…some of it is an educational issue around adjusters because it seems like sometimes case management and the administration of the money around the client have two different goals in mind. Rather than being in an adversarial position, I think, a lot of times we are well versed in quality of care issues.

Nurse case manager…pull together the fragmentation and, for example, who are the certified translators—I believe there's certification now for translators…Who are their ergonomic specialists who have gotten through a certain degree of certification? I mean we're—everybody's inventing the wheel at each insurance company.

Physician…take the IMC guidelines and make each section a CME unit and have it be readily accessible, either on the Internet or by mail, and…the upper-extremity ones should be worth three hours and the low back is worth three hours, something like that, so that—we should all know them cold and most of us have probably read them, but if we got credit for doing it.

Physician…continuing education that's done by tapes or video or TV conferences that could be spread throughout the country to try to elevate the whole group out there, whether they came in two months ago or six years ago, whether they came from family practice or whether they were really an obstetrician before and they just couldn't deliver anymore.

2 **Improve access to care for injured workers.** Several proposals were made to improve injured worker access to care.

Physicians were particularly interested in strategies to reduce hassle, through streamlining the utilization review process, reducing the paperwork required of physicians, reducing the friction of bill review and billing disputes, and making information on workers' compensation and occupational health more accessible to physicians. Improving the utilization review process was also viewed as an important strategy for improving access.

Attorney…I think there needs to be a presumptive right to some degree of mental health treatment when somebody's been out of work for a period of time.

Judge…if the issue is giving them decent treatment, then de-emphasize that and all the regulations so you can bring more people who will be willing into the system and to have better payouts for them so that it will create an incentive for them to participate.

Judge…I think we should look at the 90-day presumption, 'cause a lot of insurance companies take that as an excuse to delay.

3 **Increase accountability and use standardized performance measures.** The concept of performance measurement to assess the quality and outcomes of care provided to injured workers was discussed in all of the focus groups.

Employers, nurses, claims adjusters and workers expressed their desire for a better way to identify high quality providers or clinics. Work-

ers suggested that the results of standardized patient satisfaction surveys be widely distributed.

It was pointed out that standardized performance measures are difficult to construct in areas where the research evidence base for consensus on proper treatment is weak—further applied research on treatment and disability prevention for common work injuries would facilitate improved care and accountability.

Claims adjuster…It seems like there should be some profiling or some way of certifying them to be able to treat workers' comp.

Nurse case manager…there ought to be some more objective way of identifying who the good doctors are.

Claims adjuster…guidelines in workers' comp…they have no teeth…you need to get the outliers out but I don't know how you do that without doing some profiling and showing what their outcomes are because then you could go to them and say, look, Dr. X, it's not just me that thinks you're a quack, you never get anyone better…But why don't the guidelines have some teeth to them?

Claims adjuster…if they could start profiling the doctors, and saying these are good doctors, not just looking at the format of their report.

Employer…What their outcomes are or you know, the type of surgery they actually do, or are you having someone that's doing something experimental all the time or something that's more set by guidelines.

Employer…it would be nice if there are surveys that the state can do from, directly, the employees on clinic and treatment, and determine if these people are meeting the standards that we want! I just think these are quality checks that can help strengthen our program.

Injured worker…I think the DWC should also institutionalize and systematize a system of feedback from injured workers to get this kind of information on a regular basis.

Injured worker…There also needs to be, I think, perhaps, some way for injured workers to complain about the treating doctors…there is no one agency to complain about…about the treating doctors or the defense lawyers or any other doctor…there needs to be somebody to complain to about the medical treatment we receive.

Injured worker…I think they also need some type of a unit to police these insurance carriers, to help those doctors that are willing to be more patient-orientated, to give them a little help there. 'Cause a lot of times they are intimidated because of the largeness or the size of the insurance carrier—meaning more money.

Injured worker…I think the state needs to quantify and qualify the social costs of workers' compensation—what are the experiences of injured workers?

Physician…The data is there, it's there with the insurance companies, it needs to be amalgamated and made available to employers and insurance companies, and then that data can be used to construct preferred-provider networks—based upon our performance, not our willingness to discount. I think that that would have a definite incentive to improve quality of care.

Physician…What I would love to see is a long-term follow-up after P&S eval, to see how accurately are they being assessed at the time of P&S eval.

Physician…diagnose the specific information relating to lost time, quantity of time on modified work, total cost of the claim.

4 Create incentives to promote quality and better outcomes. There were several suggestions to create rewards and sanctions related to quality of medical care for injured workers.

Attorney…I think that there has to be some kind of a more serious consequence for the insurance companies and the physicians who refuse to learn the medicine and who refuse to recognize what they're doing to people.

Injured worker…I think the insurance companies that carry workers' compensation insurance should have tougher regulations imposed upon them to actually provide for the health care that your physician.

Judge…What you need to do, what the IMC has to do is somehow reward prompt treatment [laughter].

Judge…if you could do something to reward doing the right thing the first time around, that would be invaluable.

5 Require certification for treating providers. All of the groups addressed problems resulting from many treating physicians being unfamiliar with the workers' compensation system. Several approaches to remedy this were suggested, including more continuing medical education courses for providers and improving availability of information for providers.

Surprisingly, a proposal emerged to require certification for providers treating injured workers. Proponents of certification thought it would ensure a basic level of familiarity with the workers' compensation system and occupational health issues for all physicians treating injured workers. Others were concerned that a certification requirement might further limit access to care for injured workers by decreasing the number of physicians willing to treat workers' compensation patients.

> **Claims adjuster**…If they don't trust us I think there should be a referral source where they can get names of reasonable doctors…there should be somebody who can, who an injured worker can trust to find out the name of somebody who's good.
>
> **Claims adjuster**…couldn't there be something where instead of just mailing in a form to the IMC…the injured worker call up the IMC and say, hey, look, I need a doctor, this is where I live, and then the person at the IMC could give them some list of doctors.
>
> **Claims adjuster**…I do think it would be a great opportunity for an injured worker if they are not sure what the insurance carrier is telling them or if they are upset with their employer, that they do have another outside source to contact and say, hey look, I had an injury to my elbow. Can you tell me a doctor who just specializes in elbows versus just an orthopedic who may handle a back or, you know.
>
> **Nurse case manager**…It's too bad there's not a certification process for workers' comp competency.
>
> **Nurse case manager**…it'd be great if there was a list of people who are qualified. I don't know how you would do that.
>
> **Physician**…I think what I would do is have the carriers do whatever they want to have us pass some test, but then untie our hands…here has a full-time person who does nothing but obtain authorizations for referral.
>
> **Physician**…be some sort of certification, along with a continuing medical education program, that would provide us with the knowledge to continue to be certified.

6 Improve return to work through assisted and required provision of work modifications. Every group identified return to work barriers, and made suggestions for improving return to work outcomes.

Workers felt that employers should be required to provide appropriate modified work. Others, including employers, suggested giving employers financial assistance to implement work modifications, or financial incentives to encourage employers to provide modifications.

Several participants thought that current incentives for attorneys and workers need restructuring to promote the goal of full return to function, rather than encouraging extended temporary disability.

> **Employer**…I would like to see more doctors visit the job site, come and see what these employees really do, 'cause I don't think a lot of them have a clue. Come and see our modified jobs that we have.
>
> **Employer**…they give the employers credit for returning people back to work, and I like that. We're trying to push that through…you get credit from the state, something like that.
>
> **Injured worker**…There should be somebody you can get a hold of if—if you're given a work modification and your boss does not honor that work modification, there should be somebody that you can get a hold of that would tell them, "Hey, you need to do this or you're going to be fired, you're going to be penalized in some way," monetary, because that's the only thing that seems to work.
>
> **Injured worker**…set penalties for the employer for non-compliance. If somebody wants to work, they shouldn't be taken out of work just because the employer does not honor that limitation.
>
> **Physician**…try to pool together the modified work, in the way that the insurance companies pool, so that you may have someone who's in a factory-type plant where there actually is nothing, but we can use him as a secretarial-type, administrative-type person, filing, in for some other employer, and do this more on a community basis.

Physician…some program to encourage employers in a universal modified-duty policy… post office style, where everybody can come back to work.

Physician…we have a disability specialist who does all the modified duty…just to be able to send them down to her or talk to her, and you know they're going to have a modified job the next day. If that was available for other employers, that would be a huge difference.

7 **Improve claims handling of medical issues.** All groups made suggestions for improving claims adjuster performance with regard to medical benefit delivery.

Recommendations included more training for claims adjusters on medical care and medical issues, providing more internal resources for help with medical issues—such as more nurses and doctors on staff at insurance companies to work closely with claims adjusters, decreasing adjuster caseloads to allow them more time to talk with the injured worker or handle authorization requests in a timely manner, and requiring certification.

Adjusters felt they are so busy attending to multiple minor regulatory requirements, they don't have the time to spend with injured workers talking about problems.

Claims adjuster…If everyone had a little more ample time to work on that aspect of the cases, that'll go a long way.

Employer…the people who are adjusting these claims have only as much medical knowledge as they are able to acquire…I see the need to fill it and do a lot of training, otherwise these people have no—the adjusters, I mean—have no knowledge about medical issues and what appropriate treatment is, or any of that, and yet they're the ones making these decisions. So I think it ought to be law that insurers have a certain amount of medical expertise available to them that must be used in making their decisions.

Judge…the insurance companies and the adjusting agencies have the profit motive to keep the number of adjusters down so that they have too many cases and so they—they're human beings, they have a god-awful job, they cannot deal with all of that, so you have to have a system of incentives that [rewards] or punishes, to some extent, delays that are occurring now, keeping people from getting the care.

Judge…make sure that claims are adequately reserved early on for the unexpected medical expenses…very often what happens is they under-reserve for the medical and when the request for more expensive medical comes in…big surprise. If the claim is reserved appropriately at the beginning with an adequate reserve for medical, then the claims adjuster can authorize the treatment without having to go to a supervisor.

Judge…somehow the insurance industry has to make it better for these doctors as far as getting their bills paid.

8 **Improve the utilization review process and provide for independent medical review.** Physicians, attorneys and judges made several recommendations for improving the utilization review process. According to them, the utilization review process should be linked more closely with quality of care improvement efforts, so that under-utilization and over-utilization can both be identified.

The concept of independent medical review was discussed for providing greater medical expertise in external review of medical decisions.

Attorneys…but why the hell should a carrier have any say in what goes on? Why shouldn't it be the other way around? Why shouldn't they have to provide all the treatment the doctor recommends until some issue they want to raise is litigated?

Employer…the state should also have independent medical knowledge available to the work comp judges to help them be able to understand the medical issues that come before them.

Employer…I would also like to see the work comp judges have access to independent medical expertise. I think they need that. I think that's a big hole in the system. I don't know anywhere else in the law where you have decision-makers at that level making decisions, absent the ability to rely on needed expertise.

Judge…If we took medical treatment and we separated it and made that a priority expedited hearing, we could bring that issue solely to calendar faster, and that might provide an incentive for the insurance companies to move on that decision quicker.

Judge…If the DWC had the staff to monitor these claims, they could have a medical department that could make recommendations, independently of the insurance companies and independently of the attorneys.

Physician…just streamlining their approval process would make…a big difference.

9 **Reduce disputes and litigation, provide more information and help for workers.** Several proposals focused on methods to improve communications and provide clearer and more consistent guidance to injured workers.

Workers were very enthusiastic about a proposal that someone—advocate or ombudsperson—could help them through the system and mediate conflicts without resorting to litigation.

Injured worker…DWC could, if they had the funding or whatever, handle better for the injured workers, because there's too many of us that are frustrated and cannot get the information. If you can't even call your local number to provide competent information, you're going to be up the creek.

Injured worker…I think money well spent in California…would be an injured patient advocacy office with a representative that comes to your home…and inform us of our rights verbally and written, and give us all of those choices that we are entitled to—but not after the fact, before the fact. And if you're in the hospital, they should visit you in the hospital. If you're out in Timbuktu, they should go out there.

Injured worker…the state could assess a $25 fee on each permanent disability award, get matching funds from the insurance industry, and somehow funnel that money to injured worker support groups or injured worker information systems.

Appendix 1: Sample recruitment notices

Want to Injured Workers
Think About Their Medical Care?

The California Division of Workers' Compensation wants to help improve the quality of medical care for injured workers. To do this, we need to hear from workers about the medical care they received for a work injury.

We will be hosting a small group of injured workers to talk with us on Saturday, April 8, from 10 AM to noon, in the East Bay.

Participants will be paid .

- You were injured between January 1, 1999 and December 31, 1999, and
- You would like to talk about the medical care you received for your injury, and
- You are available on Saturday, April 8, 10 AM–noon

Please call 510-647-0610. Leave a message with your name, your phone number, and the best time to call you. One of our staff will call you back as quickly as possible.

Thank you for your interest.

Want to Self-Insured Employers
Think About the Medical Care
Their Employees Receive?

The California Division of Workers' Compensation wants to help improve the quality of medical care for injured workers. To do this, we need to hear from employers about the medical care their employees receive for work injuries.

We will be hosting two small groups of self-insured employers:
Northern California: May 1st in Sacramento
Southern California: May 5th in Los Angeles,
adjacent to LAX Airport

- You are responsible for arranging medical care your employees receive after a work injury;
- You have a role in purchasing or evaluating workers' compensation coverage including medical care; and
- You would like to talk about how to improve the quality of medical care your employees receive under workers' compensation

Call 510-647-0610 and leave a message with your name, your phone number, and the best time to call you. One of our staff will call you back as quickly as possible. The discussion groups last 2 hours.

Thank you for your interest!

Want to Physicians Think About
Medical Care in the
Workers' Compensation System?

The California Division of Workers' Compensation wants to help improve the quality of medical care for injured workers. To do this, we need to hear from the physicians who take care of patients in the workers' compensation system.

We will be hosting a small group of physicians to talk with us about medical care in the workers' compensation system. The meeting will be held on Wednesday, March 15, 4:00–6:00 PM, in San Francisco.

Participants will be paid $100.

- You are a physician who cares for patients in the workers' compensation sstem,
- You would like to talk about medical care for injured workers, and
- You are available on the afternoon of March 15 (Please note, only those who participate for the full two hours will be paid.)

Please call 415-703-4651. Leave a message with your name, your phone number, and the best time to call you. One of our staff will call you back as quickly as possible.

Thank you for your interest.

Want to Applicants' Attorneys
Think About Medical Care
for Injured Workers?

The California Division of Workers' Compensation wants to help improve the quality of medical care for injured workers. To do this, we need to hear from the people who interact with the workers' compensation medical care system.

DWC's medical director, Dr. Linda Rudolph, will be hosting a small group of applicants' attorneys to talk about these issues on Monday, October 16, from 11 AM to 12:30 PM, at the Van Nuys WCAB.

A light lunch will be provided.

- You are an applicants' attorney, and
- You would like to talk about medical care in the California workers' compensation system, and
- You are available on Monday, October 16, 11 AM–12:30 PM

Please call 415-703-4600, and ask for Ms. Pat Kirby to reserve a space.

Thank you for your interest.

Appendix 2: Focus group guides

Introduction of facilitators outline:

- Who we are
- What this project is about
- How the focus group will work
- Want to hear everyone's opinions—need to cover a lot so will curtail some discussion—no right or wrong answers—everything is confidential—want to hear opinions and feelings

Introduction of participants outline:

- Who they are
- Where they work and how long
- Other relevant experience

1. There's been a lot of discussion in the news media lately about the quality of medical care and the impact of managed care on quality.

Thinking about your own personal medical care, medical care for your children and families, and your own experiences with your physician and health plan—when you see the phrase "quality of care," what do you think it really means?

2. When you choose a health plan or doctor for yourself and your family:

How do you make a judgment about quality? What information do you use in making a decision? How confident are you that you and your family are getting high quality medical care?

3. Now think about the work that you do with injured workers and their workers' compensation claims. What are some of the more common aspects of health and medical care for injured workers that you get involved with?

4. When you're thinking about health care for injured workers, do you think there are important aspects of quality of care that are different from those that we discussed when you were thinking about your own care or your family's care?

5. When you think about your own work, and what you see happening to injured workers in the workers' compensation system more broadly, what are your particular concerns about the quality of care for injured workers? Can you give examples of cases where you had concerns about the quality of care that an injured worker was getting, and what, if anything, you were able to do about it?

6. How frequently do you recommend a treating physician to your clients? How do you decide what clinic or physician a particular employee should be directed to? What factors influence your decision? How comfortable are you in making these referrals?

7. What makes a health care provider good for injured workers, from your perspective as an applicants' attorney?

8. Do you see or feel any tensions between what you think is the best health care for the injured worker and what your concerns are from a legal perspective?

9. Who do you think is responsible for ensuring/improving quality of medical care, and what are their roles? [Prompts re roles of various parties: physician; medical group; MCO; employer; insurer; patient]

10. Are there aspects of the workers' compensation system that you think make it particularly challenging to improve the quality of care for injured workers, either in terms of the way your own work is organized or systemic?

11. Are there resources/tools/information that you think you would find personally helpful as you try to ensure that your clients get high quality health care?

12. Putting aside reality for a moment, if you could wave a magic wand, what would you change about the system to improve the health and disability outcomes for your employees?

Appendix 3: Workshop summary

The California Division of Workers' Compensation and Agency for Health Care Research and Quality jointly sponsored a two-day workshop, *Improving the Quality of Care for Injured Workers in California*, in May 2000 in Oakland, California.

Workshop goals were to broaden dialogue among stakeholders in California's workers' compensation system about health care quality for injured workers, and to encourage collaboration for advancing a quality agenda. Workshop participants represented health care providers, insurers, employers, labor, academia and government.

[illegible], assistant director of the California Department of Industrial Relations (DIR), spoke about focus on occupational injury prevention and sustained return to work. The current system may need incentives to achieve such outcomes, and DIR welcomes the opportunity to engage in constructive dialogue.

[illegible], director of the California HealthCare Foundation Quality Initiative, gave an overview defining health care quality and attendant problems of overuse, underuse, misuse and practice variation.

Without comprehensive, standardized information about delivery and outcomes, ascertaining the quality level of medical care is difficult—quality improvement efforts can help organizations diagnose and remedy their problems.

Key to quality measurement and improvement are the standardized and externally validated analytical data, including the patient's voice, with publicly disclosed results. A quality-driven health system practices evidence-based medicine, uses quality measurement and improvement, has incentives for achieving results.

[illegible], director of the Robert Wood Johnson Foundation Workers' Compensation Health Initiative, gave an overview of quality challenges in workers' compensation medical care.

As functional and vocational outcomes are emphasized, processes and results may be affected by factors out of the health provider's control, and responsibility for some aspects of care may be fragmented throughout a system involving employers, insurers and providers.

Evidence of poor quality of care for injured workers requires us to measure and improve workers' compensation health care quality.

[illegible], Harvard School of Public Health, detailed performance measurement. Perspectives on quality differ among providers, patients and purchasers, and different aspects of quality can be measured. Performance measures should be relevant, scientifically valid, feasible to use.

In addition to concerns about risk adjustment, barriers to workers' compensation performance measurement include the lack of: data access and accuracy; financial incentives or regulatory requirements; standardized measure sets and methodologies; and personnel resources.

[illegible], Institute for Health Care Improvement, introduced quality improvement initiatives. "Every system is perfectly designed to achieve exactly the results it gets" (Don Berwick).

Quality improvement requires system changes—which require leadership, clear aim and purpose, data and measurement use, small scale testing, and the deliberate spread of innovation success. In quality improvement projects: set priorities based on known problems and feasibility; avoid low impact changes; copy what others did.

[illegible], medical director for Pacific Business Group on Health, pointed out the biggest barriers to quality measurement and improvement in workers' compensation health care: lack of metrics such as comparative scoreboards on performance, and absence of rewards for quality—for employers, insurers, providers. We must build the business case for such quality.

[illegible], UC Berkeley School of Public Health, discussed return to work after low back injury, based on a large study in Ontario, Canada.

Workplace characteristics and psychosocial attributes, individual worker characteristics, clinical factors and workers' compensation system factors contribute to low back pain outcome.

The trajectory of recovery is set early after an injury, further influenced by worker expectations of recovery, and powerfully influenced by workplace response such as an offer to accommodate. Reducing excessive diagnostic testing, analgesia and rest; providing workplace accommodation the first week after injury; and intensive work-linked case management 3-12 weeks after injury are key to enhancing low back injured worker recovery.

[illegible], Travelers Property and Casualty; [illegible], Marriott; [illegible], Kaiser Permanente; and [illegible], California Labor Federation, presented different perspectives on barriers and opportunities for improving the quality of injured worker care.

Appropriateness of surgery and extensive chiropractic care should be assessed—as well as delays in employer reporting of injury, failure of providers to take an adequate history or be specific regarding work restrictions, and legal aspects of the system contributing to poor quality of care.

Treating physicians need both clinical and workers' compensation expertise. A major barrier to quality improvement is the lack of standardized benchmarks and data.

A high quality system would provide appropriate and timely care, enhance the worker's physical and emotional and vocational recovery with no economic loss, and provide workplace feedback to prevent further injury. Providers need more understanding of the workplace. Barriers to quality include system fragmentation, access delays for denied or delayed claims, and the system's adversarial nature. Many injured workers receive their care in the regular health care system, rather than workers' compensation.

[illegible], Washington Department of Labor and Industries, described the state of Washington's quality of care improvement process. Major components of the Washington State Occupational Health Services Project are its labor-business partnership, community based approach to prevention, increased accountability and incentives for providers, expanded integration and coordination of care, and dual focus on occupational health along with worker choice and satisfaction.

Strategies to improve quality include developing systems to track provider performance with regard to outcomes and satisfaction, new payment mechanisms based on performance standards, and developing occupational health centers of excellence.

Workshop participants were actively engaged in thoughtful and respectful dialogue, out of which the following themes emerged:

- Always stay focused on what's happening to the injured worker.
- There are no rewards for quality in the workers' compensation system—we need to create incentives for quality for all the participants.
- The adversarial nature of the system contributes to poor outcomes for injured workers and creates barriers to quality improvement.
- Continued engagement in respectful dialogue recognizing different perspectives is crucial.
- We can reach agreement on the outcomes that we want to measure.
- Prevention of occupational injury and prevention of disability are major goals in any quality improvement effort.
- Understand that each player has responsibilities, and clearly identify how each should be held accountable.
- We need to build on the strengths of various parties and focus on a team approach to quality improvement.
- For many workers' compensation injuries, treatment and outcomes are complex and multifactorial.
- Legal issues may adversely impact quality, for example the 90-day delay issue or the impact of PTP presumption on attorney choice of treater.
- We need standardized performance measurement and benchmark data.
- Provider reimbursement policies don't encourage practices such as patient education or discussions with employers.
- Quality of care is influenced by workplace factors such as health insurance.

• Workplace factors play a powerful role in return-to-work outcomes.

• Legislative provisions sometimes make things worse.

• Many providers are doing measurement—access, treatment patterns, disability duration, patient satisfaction—all are using different instruments and measures, and there is some question as to the validity of some measures.

• Performance measurement needs to be linked with commitment to quality improvement so that it is not perceived as punitive.

• We need more research to clearly identify areas of underuse, overuse, misuse and variation in workers' compensation care.

• A lot of resources are being allocated to inefficient processes, such as bill or utilization review, that could be diverted to quality improvement.

• Depression is a big issue, and the current system both contributes to it and creates barriers to addressing it.

• It's very important for workers to feel they can trust their treating physician.

• Care is currently very uncoordinated and disintegrated.

• We need improved communications among supervisors, physicians, workers and claims administrators.

• Focus. Pick something manageable and show that you can do something about it.

Participants were enthusiastic about continuing dialogue on these issues. There was general consensus that a smaller planning committee convened by the Division of Workers' Compensation should meet. The group will draft a proposed plan for quality improvement in the care of California's injured workers, through discussion of desired outcomes, applicable performance measures, and prioritization of possible quality improvement activities.